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Vermont State Hospital Futures Project

Conclusions & Recommendations for Implementation

DRAFT -- Final Report

January 13, 2004

Presented to:
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Department of Developmental and Mental Health Services
State of Vermont

Note:
This draft will be edited based on stakeholder feedback during the week of January 19, and a final report will be issued January 30.

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I. Executive Summary

Purpose

The purpose of the study is to develop a strategic plan for DDMHS-managed psychiatric inpatient services for the future. DDMHS wanted PCG to ensure the input of all interested stakeholders – consumer, providers, and clinicians – in the study. Major outcomes for this study included: a) a profile of the current psychiatric inpatient care provided by VSH, b) the documentation and assessment of current national trends and developments pertaining to psychiatric inpatient care systems, and c) the formulation of recommendations about the psychiatric inpatient services DDMHS manages.

Methodology

Over the course of the Vermont State Hospital Futures Study, PCG met with over 200 individuals with the purpose of gathering qualitative and quantitative information from key stakeholders across Vermont.

In order to complete a profile of current psychiatric care for adults, PCG developed data collection tools. The first collection tool was designed to capture information on the number of admissions to VSH and the designated hospitals. A second tool was developed to assess a randomly selected sample of hospital records at each of the facilities. In addition, another tool was formulated to collect information during interviews with administrators at DDMHS and the facilities, as well as focus groups. Once these data collection tools were complete, PCG worked with DDMHS to determine key interview participants. PCG conducted these interviews without DDMHS administrative staff present in order to create an atmosphere in which all participants could candidly comment on the facilities and mental health system.

The second phase of the study involved the identification of national trends and research applicable to Vermont's current system and future direction. The third phase of study involved an intense hands-on approach to gather local data in order to understand how the Vermont inpatient psychiatric care system should be modified for the future. Concurrently to the first three phases of the study, PCG reviewed several previous reports that addressed issues either related to or studies specifically focused on Vermont State Hospital.

Clinical Assessment

The PCG project team included three clinical experts in the mental health field.

Stuart Koman, Ph.D., is a Senior Clinical Consultant with expertise in the areas of behavioral health services, operations assessment, utilization management, quality management, strategic planning, and case rate reimbursement. He has helped PCG complete comparable state hospital studies in Massachusetts, Connecticut, North Carolina, Delaware, and Alaska. Dr. Koman has worked with many public and private hospitals and agencies to expand, privatize, and expand program operations. Dr. Koman has been involved in behavioral health services for over fifteen years and served as co-founder, President, and CEO of Choate Integrated Behavioral Health Care, Inc.

Paul Barreira, M.D. is Chief of Community Clinical Services and Director of Medical Education at McLean Hospital. He is also Program Director of McLean's Waverley Place, an innovative community-based rehabilitation program. Dr. Barreira is an Associate Professor of Psychiatry at Harvard Medical School. McLean Hospital is the largest psychiatric component of the Massachusetts General Hospital and Partners HealthCare System and the largest psychiatric clinical teaching and research affiliate of Harvard Medical School. Before coming to McLean in 2000, Dr. Barreira served as the Deputy Commissioner of Clinical and Professional Services for the Massachusetts Department of Mental Health from 1996-2000.

Gail Hanson-Mayer, RN, CS, MPH, CADAC is the Vice President of Clinical Operations for Sterling Resources LLC. She has 23 years of experience in the field of behavioral health, which includes senior management positions with national and local companies that provide behavioral health management and consultation services to hospitals, managed care companies, behavioral health networks and state systems of care. Ms. Hanson-Mayer continues to provide direct care to adolescents and adults in an outpatient group practice as a Clinical Nurse Specialist with prescriptive authority.

The clinical team was responsible for completing the Patient Profile as well as the Clinical Assessment components of the study. Finally, the team was instrumental in the decision-making process for the Conclusions and Recommendations pertaining to clinical practice.

Conclusions

It is important to note that there are three sources of information for these conclusions. The conclusions based on: 1) input from stakeholders regarding their experiences and perceptions of VSH; 2) data analyzed from DDMHS, and the peer state review; and 3) expertise from the clinicians who were part of the PCG project team, and clinicians at VSH. The findings from this study have implications for the future of both Vermont State Hospital and Vermont's mental health system. A brief overview of the major conclusions follows.

Vermont State Hospital

1. There is consensus that the state should ensure that there is an inpatient capacity which will play the "safety net" function for the clients who pose the most difficult clinical and legal challenges for the public mental health system.

2. VSH provides a specialized clinical function to patients who have not been successfully treated in other environments for reasons such as refusal to accept treatment, violent or aggressive behaviors, or the need for longer-term treatment that other settings cannot provide. This specialized clinical function can continue to be provided by VSH, or by another facility, either in a statewide or regional setting if the facilities develop the necessary specialized functions.

3. At the present time, the data on admissions and discharges do not provide evidence to suggest that there are an insufficient number of beds to meet

Vermont's need for state hospital services. This assumes that there is no change in the current diagnostic mix and acuity of people entering VSH. It also assumes no change in admission or discharge criteria as well as capacity of community services and designated hospitals.

4. A significant number of VSH patients – as many as 25% - could be treated effectively in community settings if appropriate service capacity was developed.

5. At the present time, VSH serves all people who refuse to take medication beyond a point tolerated by the designated hospitals. As a result this makes it difficult for the staff to maintain a therapeutic milieu with all of the patients.

6. There is an overwhelming perception as well as substantial reported experiences that VSH operates in isolation from the community mental health system, which results in poor continuity of treatment and difficult placement planning.

7. VSH serves the state's highest need consumers, both in terms of acuity and complex diagnosis, in an antiquated setting. This setting creates additional barriers to treatment. There is very limited ability to retrofit the environment to create the needed flexibility for maximum clinical effectiveness.

Other conclusions which merit further consideration and are relevant to the Vermont mental health system but extend beyond the scope of the Vermont State Hospital are included in Section XII of the report.

Recommendations & Options for Implementation

The recommendations that follow were formed based on data specifically related to the Vermont State Hospital, as well as the experience of the PCG team in other states. The recommendations go further than only planning the future of Vermont State Hospital. Rather, the recommendations serve as the beginning of a process to think broadly about Vermont's public mental health system, the populations it serves, patient needs, treatment modalities, service settings, and organizational requirements. PCG chose this approach in proposing change because VSH exists as part of a complex, statewide system of mental health services. The recommendations and options respond to the many experiences and perceptions expressed by the consumers, clinicians, staff, providers, and many other stakeholders who shared their time and ideas, hoping to improve the system of care for people served not only at Vermont State Hospital, but also in the entire Vermont public mental health system. A brief overview of the recommendations follows.

Recommendations Regarding Vermont State Hospital

1.0 Support VSH to play a unique and critical role in the Vermont public mental health system

PCG's work in Vermont and experience in the peer states leads us to conclude that VSH serves patients whose needs currently could not be adequately met by any other provider in the system. VSH must play more than just the role of "safety net." In order

to treat clients who are clinically complex, often resistant to accepting treatment and sometimes with compounding legal issues, VSH must maintain a unique clinical capacity specially designed to meet its public mission. Stakeholders were consistent in their assessment that VSH currently serves the most difficult populations in the State. Most community providers stated they are unable to serve the individuals at VSH because their facilities lack the physical plant capacity or the clinical capacity to meet the needs of these consumers.

1.1 Vermont State Hospital should serve the clients of the public mental health system who require secure inpatient treatment where their unique clinical, behavioral, and legal needs can be met through quality treatment in a setting designed for their special needs.

1.2 VSH should be staffed and designed to serve persons with a major mental illness who also meet one of the following criteria which do not allow them to be served appropriately in a community setting:

- **violent/aggressive behaviors**
- **forensic (violent, serious offender: having committed a crime involving physical harm to others)**
- **chronic medication refusal**
- **need longer term active treatment, more than designated (not community) hospitals have been able to provide**

1.3 Vermont should continue to maintain a 54 bed capacity at VSH.

2.0 Create a New Setting for Vermont State Hospital

It is clear from all sources, as well as our own site visits, that the current state hospital physical structure, including its layout, size, and condition, at best is inadequate for what is needed in a modern treatment facility, and at worse, creates barriers to serving the people who need treatment at VSH. The age and condition of the building eliminates renovation as an option to create a quality facility to support the challenging mission of the hospital.

2.1 The new setting should meet the following criteria:

- It should support and promote the best treatment approaches in its design and use.
- It should have direct access to hospital level medical care.
- It should be fully integrated with the community mental health system.
- The new setting should take advantage of all available payer sources to minimize the State's cost.

These criteria could be met by several different options that could be developed in Vermont.

- *Option # 1: Integrate VSH services within a general hospital and operate under the license of the general hospital*
- *Option #2: Construct a new state hospital facility*
- *Option #3: Create a regional hospital approach*

2.2 DDMHS should conduct a feasibility study to determine the impact of specific site options, partners, and economic considerations against the criteria for a new state hospital.

Preliminary Assessment of How the Options Satisfy the Criteria

Options	Criteria			
	New Design that Supports Treatment	General Hospital Access	Integrate with Community Mental Health System	Reduce Net State Cost
#1 Integrate VSH with a General Hospital	Medium	High	Medium	High
#2 Construct a New State Hospital Facility	High	Low-Medium	Medium	Low
#3 Create a Regional Hospital Approach	Medium	Medium-High	High	Low-Medium

3.0 Develop a Financial Strategy for the Community Services Needed to Reduce the Demand for VSH Services

The community system needs continued development to ensure that VSH is appropriately used for people who need secure, specialized, hospital level care. Although this study did not examine the adequacy of community services, the need for sustaining and expanding certain services became clear as we looked at the needs of certain persons who would use VSH.

3.1 DDMHS should develop long-term, secure community residential service options to meet the needs of persons who currently use 10-12 VSH beds.

3.2 Each Community Mental Health Center should have a full-time liaison assigned to work with VSH to ensure proper communication and coordination of services.

3.3 The small size of VSH requires new resources to meet these needs; reallocation of VSH resources to the community is not economically feasible.

Additional details on each of the options listed above are combined in Section VIII of the full report. In addition, the report includes other recommendation for consideration.

II. Purpose

The purpose of the Vermont Futures Study, as specified in the RFP, was to gather qualitative and quantitative information from key stakeholders across Vermont and nationally in order to develop a strategic plan for DDMHS-managed psychiatric inpatient services for the future.

The State of Vermont Department of Developmental and Mental Health Services (DDMHS) issued a Request for Proposals to conduct a study of adult psychiatric care in the State. Major outcomes under this RFP included a) a profile of the current psychiatric inpatient care system provided by VSH, b) the documentation and assessment of current national trends and developments pertaining to psychiatric inpatient care systems, and c) recommendations about the psychiatric inpatient services DDMHS manages. The strategic plan will assist DDMHS to better manage its resources in the context of the Vermont mental health system as the Department looks to the future.

In an effort to determine the future role of adult psychiatric inpatient services in Vermont, it was necessary to assess who is currently served, where consumers are served, and how consumers are served. This was accomplished by onsite record reviews, interviews with patients who volunteered, and observation of the Vermont State Hospital (VSH) units.

Meeting with a large number of stakeholder groups allowed PCG to synthesize a variety of perspectives on the current system. Interest was very strong. Approximately 200 stakeholders attended sessions held by PCG, with some individuals attending multiple meetings. PCG conducted the meetings with stakeholders in a variety of settings and locations in Vermont, and a few were completed by telephone.

PCG focused on working with stakeholder groups to discuss the future of the VSH and not to focus on the current problems of the facility or issues with the entire mental health system in Vermont. However, it was very difficult for people to keep their comments segregated in such a neat fashion. As many individuals suggested, to focus on the facility out of the context of the Vermont mental health system would result in inadequate proposed solutions. Repeatedly, we were told that the facility should be seen as a component of the array or continuum of mental health services available to Vermonters and should not be viewed in isolation. As a result, the report includes recommendations that are specific to Vermont State Hospital as well as recommendations for DDMHS in its role as the designated mental health authority for the State. This report focuses on the future of the public mental health system in Vermont, not the past.

The recommendations are presented in such a manner as to give the Department and its stakeholders a blueprint for certain strategic choices concerning the future of Vermont State Hospital. In addition, we have made suggestions concerning certain system-wide improvements that should be considered as well.

III. Methodology

The scope of this important study was divided into four phases: 1) a profile of the current psychiatric inpatient care provided by VSH; 2) an assessment of current trends and research developments; 3) development of ideas for the future of DDMHS and managed psychiatric inpatient care; and 4) a final report containing findings and recommendations for the future of VSH as well as other considerations around the Vermont mental health system. These four phases were designed to meet the desired goals of DDMHS and ensure that thorough data collection and research occurred over the course of this study.

In order to complete a profile of current psychiatric care for adults, PCG developed data collection tools. The first collection tool was designed to capture information on the number of admissions to VSH and the designated hospitals. A second tool was developed to assess a randomly selected sample of hospital records at each of the facilities. The audit tool was utilized to perform a clinical review of the medical records of a subset of patients at Vermont State Hospital as well as a selection of DDMHS Concurrent Review Forms of patients treated at the designated hospitals. Lastly, another tool was formulated to collect information during interviews with administrators at DDMHS and the facilities, as well as focus groups. Once these data collection tools were complete, PCG worked with DDMHS to determine key interview participants. PCG conducted these interviews without DDMHS administrative staff present in order to create an atmosphere in which all participants could candidly comment on the facilities and mental health system.

In addition to the meetings, PCG reviewed existing statutes and other Vermont state policies affecting psychiatric inpatient care. All of the information and data gathered in this phase of the project was used to develop a profile of current psychiatric inpatient care including who is being served, where and how, as well as statewide and facility-specific services, strengths, and gaps.

The second phase of the study involved the identification of national trends and research applicable to Vermont's current system and future direction. PCG staff also reviewed current literature as well as best and state-of-the-art practices. PCG analyzed these elements in terms of their impact on Vermont's current and future mental health service system.

The third phase of study involved an intense hands-on approach to gather local data in order to understand how the Vermont inpatient psychiatric care system should be modified for the future. With the help of DDMHS staff, numerous meetings were arranged across the State between stakeholders and PCG team members. Through these stakeholder interviews, PCG was able to survey individuals across the State and across various parts of the mental health system about DDMHS's role in the Vermont mental health system and to gather feedback regarding the future role of VSH.

Concurrently to the first three phases of the study, PCG reviewed several previous reports that addressed issues either related to or studies specifically focused on Vermont

State Hospital. The report titled "A System Under Siege," by *CommunityWorks*, identified the following goals for the report: expanding options for reducing seclusion, restraint, and other coercive measures. The "Report on Community Capacity for Psychiatric Acute Care of Adults" submitted by the Vermont Council of Developmental and Mental Health Services, Inc., evaluated the steps taken to transfer acute care resources from the state hospital to community services since 1994. The final report from Flint Springs Consulting, "Involuntary Treatment in Vermont: An Independent Study of Key Stakeholders," looked at the reduction of involuntary treatment.

Each of these reports included concerns around staffing (number, qualifications, training, pay, turn-over) both at VSH and in community settings as well as issues around the adequacy of the overall available funding for mental health services. In addition, the reports addressed models for service delivery, with an emphasis on the positive aspects of a recovery approach to treatment. There were concerns expressed about the negative environment at VSH, the need to improve client transitions from VSH to the community, the need for enhanced collaboration across the mental health system to improve continuity of care, and the quality, access and ability to meet the complex needs of persons within the system of services. These themes were not unlike those expressed to PCG while conducting this study.

In the final phase of the project, PCG developed a draft report based on the data collected and the experiences and perceptions of the stakeholders interviewed. The project team reviewed the specific findings and recommendations outlined in the draft report with DDHMS staff. The Department shared the draft report with Vermont stakeholders whose feedback was obtained through public video conferencing forums facilitated by DDMHS and attended by PCG staff. PCG reviewed and considered stakeholder input and made changes to the final report, as appropriate. Lastly, PCG presented the final report to the DDMHS Commissioner for submission to the state legislature.

IV. Vermont State Hospital Patient Profiles

Introduction

In order to obtain an accurate assessment of the population of patients treated by Vermont State Hospital, PCG conducted a review of the previous year's data and completed an in depth look at the current population. This review was to develop a profile of the current patients, including a look at where they come from, where they go when discharged, the barriers to discharge, and how frequently they return. PCG sought to determine if some of the patients could be better treated by community-based programs if they were available and, if so, what types of programming are needed. As part of the review, PCG conducted focus groups with patients at the hospital to obtain their input into the process. A summary of the focus group feedback is included in this report.

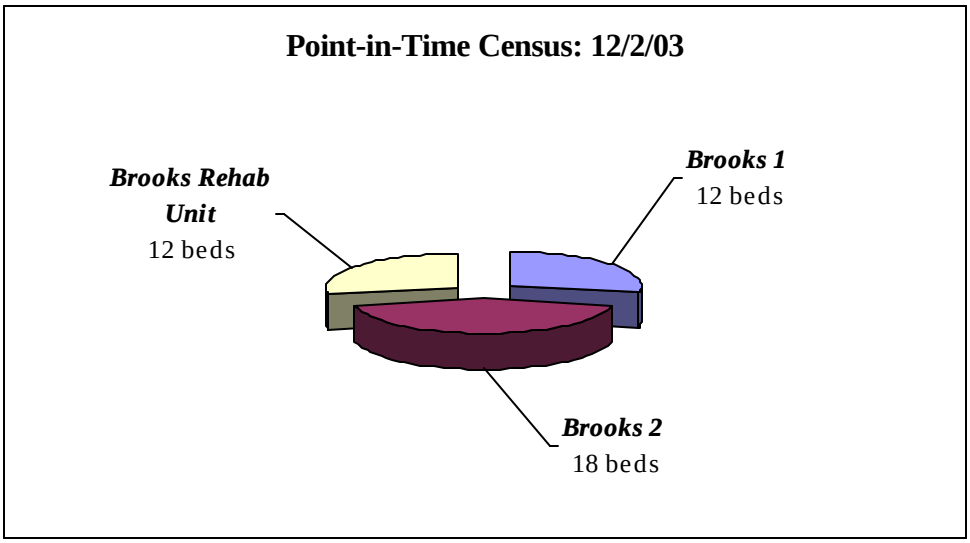
Currently, the Vermont State Hospital is undergoing a rapid organizational change as its leadership and staff attempt to improve patient care and regain certification with the Centers for Medicare and Medicaid Services (CMS). Leadership and staff are also working to regain credibility with community stakeholders. The facility is working to clarify the organizational structure and solidify the quality management system necessary to sustain improvements in patient care. There is a sense of urgency that this change must occur at all levels and that the role of the state hospital within the treatment system be clarified. The hospital has operated as an isolated component of the statewide system for a long time, and it has been in a crisis management mode more recently.

Data Review

On the date of review, there were 48 patients in occupied beds treated at VSH on three units (30 males, 18 females). An additional seven patients counted in the total census were on pre-placement visit. Census figures on each unit were:

- *Brooks 1 (men's admission/forensic unit)*: 18 patients, plus 1 patient on pre-placement;
- *Brooks 2 (women's acute admission unit)*: 18 patients, plus 5 patients on pre-placement;
- *Brooks Rehabilitation Unit (sub-acute, long-term care unit)*: 12 patients, plus 1 patient on pre-placement.

Figure IV-1



Patients were referred and admitted to the hospital through a variety of sources throughout the State. These sources frequently include the court system. The most frequent reasons cited for referral to the state hospital were:

- the degree of violence exhibited by the patient or threatened degree of violence including high assault risk;
- the refusal of the patient to accept necessary treatment, particularly medication, in order for re-stabilization and improvement in functioning to occur;
- the lack of availability of aftercare services/community placement for people with severe and persistent mental illness and other special populations served at the designated hospitals; and,
- previous treatment at the state hospital due to the level of chronicity of the patient.

Vermont screening protocol requires that two designated hospitals be contacted to determine if they can serve the patient. Only after it is determined that those hospitals are unable to serve the patient does admission to VSH occur. Although this protocol is in place, the record reviews were inconclusive as to whether or not this policy is being followed.

Through a review of the admission and referral process of the current population, it is clear that the designated hospitals throughout the State are attempting to treat more acute patients as a first line of response to a psychiatric crisis. Movement from the designated facilities to the state hospital generally occurred when refusal of treatment led to an increased level of acuity, which made the patient unmanageable at the facility. The balance of maintaining the rights of the patient to accept treatment and the delivery

of treatment are often in conflict when the consumer returns to the community system. This then triggers a referral to the state hospital.

The DDMHS Acute Care Team operates statewide to oversee and manage utilization of acute services for the adult mental health system. This team actively looks at the treatment barriers that exist within the State and works to solve these issues across providers. Data is collected to review the census at Vermont State Hospital, reasons for admission, and length of stay. The Acute Care Team has a similar role with the designated hospitals. Within the previous two years, the data identifies some significant shifts within the acute care treatment system, described below.

- Admissions for emergency psychiatric examinations to designated hospitals increased by 25% from fiscal year 2001-2003 and admissions for emergency psychiatric examinations decreased at Vermont State Hospital by 22% from fiscal year 2002-2003.

- The annual number of court-ordered psychiatric observation admissions to Vermont State Hospital remained consistent during the previous three years at approximately 100 per year. Court-ordered psychiatric admissions as a percentage of total admissions to Vermont State Hospital range from 38-47% annually.

- On average, 50% of the patients referred to Vermont State Hospital within the previous three years have a length of stay of less than ninety days.

PCG used record reviews provided separate and more specific information and gavee a clearer picture of the current VSH population. The reviews identified the major categories of patients treated at VSH and were instructive in clarifying which groups of patients might be served in other settings given the availability of alternatives. It is clear that VSH serves a wide variety of patients with complex psychiatric, medical, and social needs that are currently unable to be served in a community system. Within the State system of care, VSH provides an important role in treating these patients. In relationship to the statistics generated above, the patient population reviewed during this point in time demonstrated the following:

- 31% of the patients admitted to Vermont State Hospital were there for court-ordered psychiatric observation.

- 38% of the current population was admitted for emergency psychiatric examinations.

- 44% of the population at Vermont State Hospital had a length of stay less than 90 days.

- 22% of the population at Vermont State Hospital had a length of stay less than 30 days.

These current percentages are consistent with the previous two-year history of utilization and also demonstrate that significant trends are emerging. These trends are: (a) a reduction in length of stay and (b) a reduction in court-ordered evaluations. Data from the previous two years (FY 2002 and FY 2003) for referral for court-ordered evaluations have averaged 42% on an annualized basis. The point in time record review indicated an 11% reduction during this time period.

It is significant to note that the movement of patients in and out of the VSH in less than thirty days is an impressive statistic and is above customary standards at other comparable state hospitals. In comparable states that use the equivalent of designated hospital for acute psychiatric treatment, the State hospital beds are used primarily for patients who require longer lengths of stay than are possible in these designated hospital equivalents. This data is consistent with other data that suggests that VSH treats a sizable group of acute care patients. Furthermore, the data suggested that VSH is able to move patients who have been transferred from an acute psychiatric unit in a relatively short time (e.g. the median is four months).

Special Populations

There are special categories within the population of individuals served at Vermont State Hospital that were evident within the point of time review. These groups of patients are categorized as: forensic, geriatric, traumatic brain injured, and dual diagnosis (mentally ill / substance abuse). These populations tend to be the more difficult to treat and discharge to a community setting. Due to the perceived level of dangerousness, discharge of the forensic population can be a source of community concern. People with TBI are difficult to treat in the community because they exhibit unpredictable aggressive and assaultive acts. Their behaviors are difficult to control with complicated medication regimes and the population requires specialized staff in 24 hour supervised settings. People with dual diagnoses require integrated care by staff who are trained to recognize and treat both illnesses simultaneously. In addition, they are known for frequent relapses which require police intervention or emergency psychiatric intervention. The percentage spread of these identified special populations represented the following: 30% forensics, 16% geriatrics, 6% traumatic brain injury, and 10% dual diagnosis. The remainder of the individuals was patients categorized as having severe and persistent mental illness with a predominant diagnosis of Major Thought Disorder.

On the date of review, 30% of the patients at Vermont State Hospital were deemed of forensic status. This includes the following three categories: court ordered evaluations, those adjudicated and deemed incompetent, and those competent but insane. Of the total forensic population, 65% were committed as incompetent and 35% were deemed competent but insane. There was a wide range in level of severity of criminal behavior in the forensics category. Individuals who committed serious crimes were housed on the unit with patients with severe mental illness who had committed misdemeanors. In reviewing the diagnoses associated with the individuals admitted or present under a forensic legal status, less than 10% of the population carried a diagnosis of Personality Disorder. In reviewing the statistics for the previous two years this percentage

fluctuated from a low of 14% to a high of 28%. In considering the role of VSH in serving this population, the critical importance of creating a framework for developing greater coordination and collaboration with the courts and Department of Corrections is evidenced. There is the opportunity to develop joint treatment programs that might better serve this population, more specifically serious offenders. Within this population there are patients with co-morbid psychiatric diagnoses who warrant acute psychiatric treatment and intervention. Once stabilized psychiatrically the need for longer term, secure residential care becomes evident. The blending of the severity of criminal behavior and level of acuity of this treatment population within the milieu presents special challenges and difficulties to the staff and clinical leadership team at the hospital.

The patient population labeled as geriatric at the time of evaluation consisted of 16% of the population, with the majority of these individuals being 55-65 years old. There was one patient who is 88 years old. This group of patients was divided in half by length of stay. Fifty percent had a length of stay less than 90 days. There are a significant percentage of patients in the geriatric population, with a diagnostic category of major thought disorder. These patients were primarily female. This population might be better served in a community-based program that would provide services specific to the needs of this population. There is an increased need by virtue of age for closer collaboration with medical care for the geriatric population.

Patients labeled as having a dual diagnosis were under-reported diagnostically in the previous two years. Current literature has reported that the diagnosis and treatment of co-occurring disorders in the mentally ill population is frequently under recognized and under-treated. This results in increased recidivism and poor treatment outcomes. DDMHS has initiated a statewide training initiative to improve diagnosis and treatment interventions for this population. As the system increases their awareness, this is likely to reduce the need for these individuals to be hospitalized in an acute setting such as VSH. Data reviewed indicated that 10% of the patient population was reported to have a co-occurring substance abuse disorder. This percentage is low. Clinical records indicated a much higher presence of substance use within the current patients. Sixty-six percent (66%) of the records reviewed indicated a history of substance abuse. Appropriate assessment and identification of co-occurring substance abuse is necessary to promote recovery and prevent recidivism. The current literature emphasizes the need to treat both disorders simultaneously in order to prevent relapse and improve quality of life.

Patients with TBI were represented as 6-10% of the population. These patients require specialized treatment approaches and long term, residential care. An important component of the treatment planning and clinical process for treating patients with brain disorders is staff training on how to develop positive behavioral support plans. This group represents a smaller percentage of the population. Due to the level of organic impairment which limits their ability for sustained clinical improvement, there is an ongoing need for 24-hour supervised care in a less acute setting.

Meeting with Consumers

The following section reports the feedback and perspectives conveyed by VSH patients at that point in time during the course of the record reviews and patient profiles component of the study. While this is a piece of the VSH Patient Profiles, readers should not attempt to make any clinical inferences or interpretations from this information. If additional information is sought regarding the viewpoints of VSH patients, Discharged Patient Satisfaction Surveys dating back to January 2003 are available from the Quality Assurance Department of VSH.

A focus group was held at Vermont State Hospital to obtain input and recommendations from the current patients receiving acute care. An open invitation was provided to all patients on Brooks 2. The patients that attended provided interesting and informative information regarding the current state of affairs at the facility and made suggestions regarding improving clinical care. The overwhelming message was that there was a significant need for additional treatment programming. There was a sense of unit confinement and lack of activities which increased the level of dangerousness on the unit, as patients are in a small space with little to do. There was an expressed need for more work therapy programming and access to an outside space. Current clinical practice encourages a recovery-based model of treatment for chronic mental illness with the focus of treatment being patient centered. In listening to what the patients expressed there is a need for a redefinition in the delivery of care at Vermont State Hospital that keeps the patient at the center of their treatment while at the same time working towards promoting acceptance of treatment.

The patients also expressed the desire for access to more programs where they would develop work skills and get paid. There was a suggestion of moving the State Hospital to a farm-like setting and/or developing vegetable gardens on the hospital grounds. Concern was raised that the current model of treatment was too medically focused, although there was agreement that there had been improvement in the communication from the VSH doctor regarding care. The Nursing Staff were seen as both available and helpful as well as lacking in trust of the patients. Concern regarding access to medical appointments when needed was raised. Discharge from the hospital was a primary concern for each patient. Concerns regarding housing, availability of work and resolution of legal issues were voiced.

V. Clinical Assessment

Vermont State Hospital currently provides services to a wide range of patients requiring different types of specialized care and treatment environments. However, neither the physical space nor the training of staff is adequate to meet such a broad expanse of patient needs. This section discusses the types of patients who are likely to continue to require long term, secure treatment and the types of treatment environments that are most appropriate for them. In conducting this analysis, we have focused on the needs of patient groups and not the current facility configuration.

Designated Facilities Can Accommodate Most of Vermont's Acute Care Needs

Most of the patient populations currently represented at VSH will require ongoing secure treatment at a specialized facility. The one major exception to this is the acute care population representing somewhere in the neighborhood of 20 - 25% of admissions to VSH because of proximity and/or historical reliance on the institution. VSH data indicate that 7 to 13 beds, at any given time and averaging just over 11 beds per month, appear to be used for individuals who stay 30 days or less. Many individuals with similar types of clinical presentations are currently accommodated at the community based designated hospitals. Our review of these programs indicates that the designated hospitals have become more flexible and adept at treating a wider range of acute psychiatric conditions and may be able to expand their reach a little further.

This expansion may be able to happen due to advances in psychopharmacology which have greatly aided this developing capacity; all indications suggest that new compounds for treatment of psychiatric disorders will be even more potent or fast acting and may cause less side effects that require ongoing medical monitoring or contribute to patient non-compliance. However, further expansion of the designated hospitals effectiveness and a resultant decrease in the use of VSH for acute care is probably more dependent on administrative changes rather than clinical or scientific advances. Three specific changes are indicated:

1. Improvement in the ease of transporting patients to and from designated hospital locations. This would facilitate the placement of patients in the most appropriate facility that has an available bed as quickly as possible.

2. Discussions focused on improving the legal process that has jurisdiction over "refusal to treat" cases. Designated hospitals are willing to attempt to engage these patients in treatment, but are unwilling to provide custodial care for the long periods of time currently required to move through the involuntary medication process because of the impact (disruption to the milieu, drain of staff time) it has on staff and patients.

3. More effective use of court-appointed psychiatric evaluators. Other states have used the court evaluator to move individuals with minor charges into a treatment setting while conducting a forensic evaluation. In most instances, the individuals will accept treatment while undergoing an evaluation. It is possible

to send them to designated hospitals and conduct the evaluation there. At the end of the evaluation, the patient can either remain at the designated hospital or be sent to VSH. It is important to note that screeners from the CMHCs perform this function (i.e. they recommend to the court where the person should go for the court-ordered evaluations). As a result, many of the evaluations actually do occur in community settings rather than VSH. However, there is a need to examine how to make the screener function more effective and insure that only court-ordered evaluations at VSH occur only for people who are violent / aggressive and alleged to have committed serious crimes. Examples include homicide, fire setting, assault with a deadly weapon, sexual assault, manslaughter.

The designated hospitals remain insistent that a "safety valve" facility is necessary for them to fall back on when confronted with persistently violent patients and patients who refuse treatment. In fact, they are clear that not having another place to send these patients would actually make them less flexible because they would "screen out" patients who they would otherwise attempt to treat.

In some states, patients cannot be admitted directly to state hospital beds, but must first be admitted to a designated facility and if not treatable there then the patient is transferred to a state hospital bed. In Vermont, there is a policy that states admission to VSH only occurs when two other designated hospitals have refused to admit the proposed patient for emergency exam.

Populations Requiring Secure Treatment

There are several groups of patients at VSH who are difficult to treat and represent populations that will continue to require secure treatment. PCG has found this to be true in other states where it has performed similar assessments. This group includes:

- patients who have committed serious legal offenses, have been adjudicated, and are deemed to be dangerous (violent and / or serious offender) forensic;

- patients who are diagnostically complex, medically and / or cognitively impaired, and sometimes dangerous (often individuals who are refusing treatment are a subset of this group); and,

- patients with severe character disorders who also have (generally) a history of substance abuse and are intermittently impulsive or explosive.

1. <u>Forensic Population (violent and / or serious offender)</u>

How to serve the forensic population described above is perhaps the most difficult question to answer. This group requires incarceration due to their legal status and dangerousness to others and an environment that can tolerate their symptoms and provide treatment if warranted and accepted by the patient. In other New England states, there are accommodations for these individuals in specially designed hospital-

based prison like units (Whiting Institute at CVH in Connecticut) or in prison-based, treatment capable programs (forensic unit at Massachusetts Correctional Institute – Bridgewater). The question for Vermont is whether it makes sense to "buy or build" this service and this is a mainly a matter of what the projected need for the service is likely to be. Based on available data at this point in time, there does not seem to be a "critical mass" of patients at VSH that would make it economically feasible to develop a separate program for this group. However, there may well be other patients in the criminal justice system requiring a similar environment who could be co-located were DDMHS and Corrections to agree to work together in this area. Alternatively, the possibility of purchasing this service from another state could be explored.

As a next step in the process of determining how best to meet this need, a cost benefit analysis should be done. This analysis would look at the population, projected utilization over the next five to ten years, determine the cost to develop the needed services, and compare that cost to the cost of outsourcing (if available). It should be noted as one proceeds with this analysis that there are a number of patients at VSH considered to be "forensic" who have been charged with lower level, generally misdemeanor crimes. These patients do not fit the profile for a highly secure unit and should be able to be accommodated in designated hospitals as previously discussed. Other states have had great success with "mental health court" programs that divert this group to treatment early in the criminal process.

2. Diagnostically complex; refusal to treat population

This population is challenging for a variety of reasons including its diversity, potential dangerousness, and (sometimes) medical complexity. A hospital environment is necessary for this group. It is important to note at the outset of this discussion that while PCG discusses the clinical needs characteristic of consumers with these issues, this is not a stand-alone population. Consumers who are diagnostically complex and / or refuse treatment are mixed throughout other distinct psychiatric diagnosis groups. Because of the unique characteristics of the individuals, the treatment, where accepted, is mostly individual with the possibility of some occupational therapy and recreation programming. This population is composed of individuals with a wide range of Axis I psychiatric disorders, substance abuse disorders and co-morbid medical and developmental conditions, including individuals with limited cognitive capacity due to traumatic brain injury, mental retardation, and dementia / Alzheimer's disease. Individuals in this group have histories of multiple hospitalizations and treatment failure. Some of these individuals are older as well or have medical illnesses that have gone untreated due to their psychiatric disease and lifestyle. Individuals refusing treatment are part of this group. They are, in essence, receiving custodial care despite efforts of staff to engage them in treatment. They are housed at VSH because of their potential dangerousness; staff interact with these patients in an attempt to engage them in treatment while providing behavioral control.

For this group of patients, access to a full array of medical specialty consultation is a key feature of the treatment environment. Other primary features of this program include:

- A physical space meeting the safety requirements for a locked unit
- A physical space that provides for easy observation by staff
- A physical space that provides ample room to move around for patients
- Single bed rooms
- Seclusion and "sensory" rooms
- A high staff to patient ratio and staff skilled in the use of behavioral treatment modalities
- A highly structured and individualized activities program that focuses on activities of daily living and symptom control
- A sophisticated psychosocial rehabilitation program that includes vocational rehabilitation for the longer stay patients
- Routine and ongoing staff development and support to combat "burn-out"

3. Character disordered population (with major mental illness)

This group is composed of individuals with character disorders, major mental illnesses, and a high percentage of co-occurring substance abuse disorders. These individuals are intermittently suicidal or dangerous to others. Accepted tenets of best practice prescribe simultaneous treatment of both the substance abuse and psychiatric disorder. Intensive treatment that focuses on developing cognitive and behavioral controls of impulsive and explosive behavior can be effective for this group. Dialectic Behavioral Therapy (DBT) and Cognitive Behavioral Therapy (CBT) are a major part of the treatment of choice for this population; medications that help to weaken the impact of an emotional stimulus or delay the need to strike out provide assistance to the individual as they learn to handle themselves in "triggering" situations. It is also counter therapeutic to physically place these individuals with the groups previously discussed in this section as they are highly manipulative and "skilled" at setting off less cognitively intact patients

While individuals in this population require a secure environment, hospital level of care is not indicated most of the time. A secure residential environment with a strong treatment program and an average length of stay in the range of four to six weeks is a far better choice from both a clinical and cost perspective. Delivering quality care to this population is dependent upon the training and quality of staff, but does not require twenty-four hour supervision by medical personnel. The most efficient way to start one of these programs, if possible, would be to expand the services of a well-performing program that already exists in Vermont.

4. Treatment Refractory Population

This is a subset of patients who are not completely responsive to medication or are only partially cooperative in taking medications, who are very symptomatic with psychotic symptoms, and often exhibit violent behavior. These patients require longer hospitalizations with multiple medication trials and a safe therapeutic environment. Diagnostically, these are patients with a psychotic illness, e.g. Schizophrenia, schizoaffective, or bipolar illnesses. In the current clinical environment, state hospitals are the only facilities that have the capacity to keep patients in an inpatient setting long enough to complete the necessary treatment. This treatment environment should

maintain continuity between the community treatment team and the residential / hospital program.

Looking into the Future

The previous analysis suggests that in the foreseeable future, the greatest impact on the need for a VSH or suitable replacement will come from state leadership and organizational changes rather than medical and scientific breakthroughs. Major questions that affect the size and role of VSH include:

1. Will funding be adequate to provide timely, effective outpatient care for individuals to both prevent the need for hospitalization or to provide adequate aftercare?

2. Will resources be available to provide intensive treatment, housing and supervised living for individuals coping with severe illnesses?

For both items #1 and #2, the presence of Program of Assertive Community Treatment (PACT) programs that meet the criteria for pact (not simply more intensive case management) have proven in the literature to reduce hospitalization and use of beds while at the same time increasing community tenure. The presence of this program would have an impact on the high utilizers / repeat hospitalization of the non-character disorder population. PACT programs would be particularly helpful in the co-morbid substance abuse / psychiatric illness group because the intensive intervention allows for better compliance with both substance and psychiatric treatment. In addition, the early intervention prevents the use of hospital level of care.

3. Will DDMHS be able to effectively engage the legal system to address issues that assist the designated hospitals in their efforts to engage treatment resistant individuals and divert misdemeanor forensic patients from VSH or jail?

4. Will DDMHS and the Department of Corrections effectively engage with one another to develop a planned approach to incarceration of dangerous forensic patients?

5. Will DDMHS and the community mental health system be able to change the current "rehabilitation unit" to a long-term residential setting with more rehabilitation and less medical / nursing support? (The patient behaviors on this unit do not require a locked, 24-hour psychiatric nursing environment.)

<u>Other Areas for Consideration:</u>

Advances in pharmacology are a certainty, too. The past ten years have witnessed very significant changes for the population served by VSH in the development of Selective Serotonin Reuptake Inhibitors (SSRIs) and the atypical anti-psychotic medications. However, these medicines are in a refinement stage at this point and are unlikely to have much impact in the foreseeable future on the population groups discussed in the

last part of this section. This may be speculative and not necessarily relevant for planning of the next 5 - 10 years, but there is promise in the use of imaging and "personal medicine," genetically targeted compounds that are built specifically for each individual. Beyond that, research and drug development in the treatment of addictions is likely to have the greatest impact on populations that DDMHS is responsible for and society as a whole.

In the long term, population aging will be a major factor, not only of individuals with mental illness, but the aging of the caregivers as well. As people live longer, the pool of those potentially needing treatment and care expands at the same time that the pool of service providers / caregivers is shrinking. The workforce issue deserves attention as well.

VI. Peer State Comparison Analysis

Overview

As part of this study, PCG conducted a comparative analysis of other states. PCG selected ten states for the peer state comparison. These states either neighbor Vermont or have a reputation as a progressive mental health system, attempting to maximize the use of community-based resources. A listing of the selected states, with populations obtained from Census 2000, is included below.

Table 1 - Peer State Selection Criteria

State	Population	Region
Connecticut	3,405,565	New England
Maine	1,274,923	New England
Massachusetts	6,349,097	New England
Michigan	9,938,444	Midwest
Minnesota	4,919,479	Midwest
New Hampshire	1,235,786	New England
Ohio	11,353,140	Midwest
Pennsylvania	12,281,054	East/Mid-Atlantic
Vermont	608,827	New England
Wisconsin	5,363,675	Midwest

The population figures are particularly helpful in a peer state analysis as they allow for standardization of data. For example, in the table detailing the bed utilization of state-operated facilities and beds, the number of staffed beds differs greatly between Minnesota and New Hampshire (929 and 237, respectively). Once this information is standardized for the difference in population, it is evident that the number of staffed beds across the adult population is very similar (26.1 and 25.6, respectively). For this reason, the peer state comparison focuses on the standardized amounts.

PCG also sought to collect comparable data across the peer states. The information we gathered was for adult populations only. Therefore, the beds, admissions, and average daily census reflect amounts for adults only. The data also includes information on both civil and non-criminal forensic beds and clients. Similar to Vermont, some other states do not have designated forensics beds. As a result, PCG included non-criminal forensic bed information from the staffed bed count. Despite our efforts to collect consistent data from states, not all states capture forensic information in their numbers. For example, New Hampshire's Division of Behavioral Health, does not manage forensic services for its consumers; instead the Department of Corrections manages these designated beds. A similar case occurs in Michigan; their bed use number may be undercounted.

The utilization data collected from the peer states is included in the Table 2. These data elements illustrate how various state mental health systems are using their resources for public inpatient care. It is important to note that despite efforts to gather data as consistent as possible, there are inherent differences in terms of how state's allocate and manage inpatient resources. It is also important to note that the strength of the

community-based service system is directly related to the need for inpatient services. Vermont is known nationally for its strong community-based system of care. Because we did not compare community services, resources, or penetration rates, the following table must be viewed simply as how peer states choose to invest resources in public inpatient facilities.

Peer State Comparison Findings & Conclusions

The peer state comparison study indicates that Vermont is at the low end of the spectrum in terms of the use of its resources for state inpatient care. Its admission rate is about average.

This data confirms previous analysis that Vermont manages its inpatient care aggressively, minimizing lengths of stay for acute admissions. It also underscores the fact that Vermont devotes a relatively small amount of its resources to providing continuing inpatient care for persons with special needs. This creates a unique Vermont dilemma: there are some people at VSH who can and should do better in community settings, but there are no available VSH resources that could be allocated to meet their needs. Also, as the VSH census goes down, the small number means the cost of treatment per person at VSH will rise. The small size of VSH offers few alternatives. At the present time, it does not seem feasible for VSH to reduce overhead costs by reducing the current bed capacity.

Table 2 - Peer State Comparison: State Hospitals - Staffed Beds per Adult General Population

State	Population	Over 18 Population	State Staffed Beds	State Staffed beds per 100,000	Admissions	Admissions per 100,000	ADC	ADC per 100,000
Connecticut	3,405,565	2,564,390	378	14.7	1,925	75.1	581	22.7
Maine	1,274,923	974,041	191	19.6	884	90.8	169.4	17.4
Massachusetts	6,349,097	4,850,710	1,089	22.5	2,317	47.8	1,048	21.6
Michigan	9,938,444	7,344,510	929	12.6	2,248	30.6	944.8	12.9
Minnesota	4,919,479	3,630,576	539	14.8	1,198	33.0	546	15.0
New Hampshire	1,235,786	926,839	184	19.9	1,007	108.6	168.2	18.1
Ohio	11,353,140	8,469,442	1,221	14.4	6,641	78.4	1,085	12.8
Pennsylvania	12,281,054	9,358,163	2,300	24.6	1,638	17.5	2,338	25.0
Vermont	608,827	461,491	54	11.7	240	52.0	56	12.1
Wisconsin	5,363,675	3,995,938	1,041	26.1	2,118	53.0	939.4	23.5
Median				***17.2***		***52.5***		***17.7***
Mean				***18.7***		***47.4***		***18.6***

Notes:
Connecticut: Bed number represents total number of civil commitment beds only.
Maine: Data is given for the State's two inpatient facilities, Bangor Mental Health Institute and Augusta Mental Health Institute. Bed data does not include forensic beds.
Massachusetts: The Department of Mental Health (DMH) is in the planning stages of reducing its number of adult staffed beds to approximately 750. This would result in 15.5 staffed beds per 100,000.
Michigan: Data do not include forensic beds.
Minnesota: ADC is given as a system-wide number (includes 114 children / adolescent beds).
New Hampshire: The State also staffs 28 children / adolescent beds. Forensic data is not included since The Department of Corrections administers the 53-bed forensic component, not the Division of Behavioral Health. There were 351 children / adolescent admissions.
Ohio: Bed data includes 145 designated forensic beds. Similar to MA, some civil beds may be occupied by forensic consumers at any given time.
Wisconsin: Civil and forensic beds are included. There were 989 civil admissions and 12 forensic admissions for child / adolescent beds.

** Population data comes from Census 2000. Data from Wisconsin, New Hampshire, Pennsylvania, Vermont, Ohio and Massachusetts come from FY 2002. Other state data comes from FY2001*

VII. Conclusions

Over the course of the statewide study, PCG met with approximately 200 stakeholders across the mental health system which included state employees and officials, providers, and consumers. PCG was able to obtain an array of perspectives and gather extensive information surrounding VSH and the mental health system. PCG also conducted a thorough review of VSH data, patient records, designated facilities, and peer states utilization data.

From this array of data and information, we were able to formulate numerous conclusions which have been discussed in detail in the previous sections. It is important to note that there are three categories of conclusions. There are conclusions based on: 1) input from stakeholders regarding their experiences and perceptions of VSH; 2) data from DDMHS, and the peer state review; and 3) expertise from the clinicians who were part of the PCG project team, and clinicians at VSH.

The conclusions from this study have implications for the future of both Vermont State Hospital and Vermont's mental health system. These conclusions are presented below by the area they most specifically impact.

Vermont State Hospital

1. There is consensus that the state should ensure that there is an inpatient capacity which will play the "safety net" function for the clients who pose the most difficult clinical and legal challenges for the public mental health system. *This conclusion is based on input received from stakeholders.*

2. VSH provides a specialized clinical function to patients who have not been successfully treated in other environments for reasons such as refusal to accept treatment, violent or aggressive behaviors, or the need for longer-term treatment that other settings cannot provide. This specialized clinical function can continue to be provided by VSH, or by another facility, either in a statewide or regional setting if the facilities develop the necessary specialized functions. For example, these functions would include the ability to provide a secure environment, care for people who refuse treatment, and have the capacity to provide long-term residential treatment. *This conclusion is based on VSH data and clinical expertise.*

3. At the present time, the data on admissions and discharges do not provide evidence to suggest that there are an insufficient number of beds to meet Vermont's need for state hospital services. This assumes that there is no change in the current diagnostic mix and acuity of people entering VSH. It also assumes no change in admission or discharge criteria as well as capacity of community services and designated hospitals. *This conclusion is based on data analysis.*

4. A significant number of VSH patients – as many as 25% - could be treated effectively in designated hospitals if issues such as transporting of patients and improvements

in the court process regarding timeliness of decisions were resolved. *This conclusion is based on data analysis and clinical expertise.*

5. At the present time, VSH serves all people who refuse to take medication beyond a point tolerated by the designated hospitals. As a result this makes it difficult for the staff to maintain a therapeutic milieu with all of the patients. *This conclusion is based on data analysis and clinical expertise.*

6. There is an overwhelming perception as well as substantial reported experiences that VSH operates in isolation from the community mental health system, which results in poor continuity of treatment and difficult placement planning. *This conclusion is based on stakeholder input.*

7. VSH serves the state's highest need consumers, both in terms of acuity and complex diagnosis, in an antiquated setting. This setting creates additional barriers to treatment. There is very limited ability to retrofit the environment to create the needed flexibility for maximum clinical effectiveness. *This conclusion is based on stakeholder input and clinical expertise.*

The conclusions below are relevant to parts of the Vermont mental health system and extend beyond the scope of the Vermont State Hospital. However, these points merit further consideration.

Community Mental Health System

- The community mental health system lacks sufficient long term residential care to treat consumers with special needs. Specifically, VSH patients who live on the Brooks Rehabilitation Unit could live in community settings if additional targeted investments were made to create this capacity.

- A consistent and effective process for liaison between the community mental health services and VSH need to be established. In some areas of the state, this liaison role clearly exists while in other areas it has been cut back or eliminated. The absence of the liaison relationship has a direct impact on the continuity of care.

- The process for determining where court-ordered evaluations needs to be reviewed to insure that community mental health services and the designated hospitals are used to conduct assessment of individuals whose acuity levels do not require the level of treatment provided by VSH.

- The resources available in the community, both clinically and financially, are perceived to be inadequate for serving persons with very high needs. Availability of psychiatrists and psychiatric nurses is a serious concern, especially in rural areas.

- Adequate training for all treatment staff across the state to insure that they are clinically competent in such areas as trauma or safely addressing aggressive behaviors needs to become a priority.

Department of Developmental and Mental Health Services

- The DDMHS System of Care Plan is not widely recognized by many stakeholders as an adequate strategic mental health plan for the State of Vermont.

- The Mental Health Board appears to be inactive.

- There is a perception of a role conflict in which DDMHS functions as a regulator, payer for mental health services, and provider of services at the Vermont State Hospital.

VIII. Strategic Plan: Recommendations & Options for Implementation

The conclusions outlined in the previous section are based on three months of focus groups, interviews, site visits, and clinical reviews concerning the future of Vermont State Hospital. The recommendations that follow were formed based on data specifically related to the Vermont State Hospital, as well as the experience of the PCG team in other states. Addressing these issues successfully will require careful consideration of the related costs and benefits of the option(s) the State chooses to pursue.

The recommendations and options discussed below go further than only planning the future of Vermont State Hospital. Rather, the recommendations serve as the beginning of a process to think broadly about Vermont's public mental health system, the populations it serves, patient needs, treatment modalities, service settings, and organizational requirements. PCG chose this approach in proposing change because VSH exists as part of a complex, statewide system of mental health services. The recommendations and options respond to the many experiences and perceptions expressed by the consumers, clinicians, staff, providers, and many other stakeholders who shared their time and ideas, hoping to improve the system of care for people served not only at Vermont State Hospital, but also in the entire Vermont public mental health system.

Recommendations Regarding Vermont State Hospital

1.0 Support VSH to play a unique and critical role in the Vermont public mental health system

PCG's work in Vermont and experience in the peer states leads us to conclude that VSH serves patients whose needs currently could not be adequately met by any other provider in the system. The role of VSH must be confirmed and clarified. The decision of who should be served at VSH has a significant impact on what type of facility Vermont needs, how large it should be, and how it should work with the entire mental health community system.

Stakeholders were consistent in their assessment that VSH currently serves the most difficult populations in the State. Most community providers stated they are unable to serve the individuals at VSH because their facilities lack the physical plant capacity or the clinical capacity to meet the needs of these consumers. As a result, some community facilities attempt to treat consumers with complex needs knowing that VSH serves, at the very least, as a "safety net." Without a safety net, many providers would be reluctant to take these risks.

However VHS must play more than just the role of "safety net." In order to treat clients who are clinically complex, often resistant to accepting treatment and sometimes with

compounding legal issues, VHS must maintain a unique clinical capacity specially designed to meet its public mission.

1.1 Vermont State Hospital should serve the clients of the public mental health system who require secure inpatient treatment where their unique clinical, behavioral, and legal needs can be met through quality treatment in a setting designed for their special needs.

When specifying the people to be treated at VSH, for at least the foreseeable future, we must also determine the potential capacity of the community system. The question becomes whether or not the hospital should serve the same population it serves today or the same population less those who can receive quality treatment and service in the community mental health system. PCG concludes that it is in the best interests of the State of Vermont and persons served by its public mental health system to continue to push for improvements and expansion of community care, as supported by improvements in treatment. This leaves VSH with a specific patient focus.

1.2 VSH should be staffed and designed to serve persons with a major mental illness who also meet one of the following criteria which do not allow them to be served appropriately in a community setting:

- **violent/aggressive behaviors**
- **forensic (violent, serious offender: having committed a crime involving physical harm to others)**
- **chronic medication refusal**
- **need longer term active treatment, more than designated (not community) hospitals have been able to provide**

If the population served at VSH is limited to those who meet the criteria listed above, then some patients currently served at VSH would need service alternatives developed to meet their needs. These specific services are discussed later in this section.

Determining the size of the hospital, its bed capacity, is confounded by the cost inefficiencies of small, intensively staffed inpatient care and the inability to predict how the community system will develop. Vermont has the smallest state hospital capacity among its peer states, and one of the smallest in the country. This is the result of a strong vision of a comprehensive community system, one that is committed to serving people in the least intensive setting, closest to home. We have noted that as many as one-quarter of the patients VSH serves (using 10 to 12), could be better served in a properly financed and staffed community setting. However, we believe it would not be practical to assume that these community services will be available.

1.3 Vermont should continue to maintain a 54 bed capacity at VSH.

DDMHS may want to revisit this recommendation when, in fact, additional resources are forthcoming to create an expanded community capacity that could replace approximately one-quarter of the persons VSH serves. However, the small number of

beds at VSH may make further reductions in size financially impractical. This bed capacity at VSH will have to remain at 54 until such a time as the other recommendations for creation of alternative services are implemented. It is not feasible to eliminate the VSH capacity until other resources are created.

2.0 Create a New Setting for Vermont State Hospital

It is clear from all sources, as well as our own site visits, that the current state hospital physical structure, including its layout, size, and condition, at best is inadequate for what is needed in a modern treatment facility, and at worse, creates barriers to serving the people who need treatment at VSH. The age and condition of the building eliminates renovation as an option to create a quality facility to support the challenging mission of the hospital.

2.1 The new setting should meet the following criteria:

- **It should support and promote the best treatment approaches in its design and use. The hospital's layout, materials, circulation, security, and other design features should reflect industry best practice. It should be capable of supporting patient populations with different treatment needs, including those who choose not to use medication.**

- **It should have direct access to hospital level medical care. Many VSH patients suffer from multiple illnesses and require medical treatment from a full continuum of health care services. Access to a general hospital would provide the necessary level of care.**

- **It should be fully integrated with the community mental health system. Providing the right kind and amount of hospital care is dependent upon close coordination with community services. Poor coordination contributes to longer stays, higher costs, and less effective treatment. The new setting must be managed as an integral part of the State's community mental health system.**

- **The new setting should take advantage of all available payer sources to minimize the State's cost. Stand-alone psychiatric hospitals limit the revenues that can be earned by billing third party payers, particularly Medicaid. The new facility should operate under the license of a general hospital to maximize revenue opportunities, and reduce the net cost to the State.**

Some or all of these criteria could be met by several different options that could be developed in Vermont.

Option # 1: Integrate VSH services within a general hospital and operate under the license of the general hospital

The assessment regarding the future of VSH's physical plant should look at the linking of the state hospital to a general hospital. Locating VSH services at one or more general hospitals creates access to health care as well as the opportunity to earn considerable Medicaid revenues that a state psychiatric facility cannot access under the current Centers for Medicare and Medicaid Services (CMS) regulations. Using more than one general hospital improves geographic access as well. To take full advantage of this option, VSH services would need to be provided under the license of the general hospital. This requires the operational integration of VSH within the general hospital environment.

PCG received consistent feedback from Vermont stakeholders that a continuing issue facing VSH is the difficulty in meeting the physical health needs of consumers served there. In addition, there is a developing trend that the aging population with mental illness who experience a host of physical health problems related to aging is increasingly difficult to treat. Locating VSH under the auspices of a general hospital would address these issues.

Option #2: Construct a new state hospital facility

Numerous stakeholders suggested that a new physical plant for VSH should be constructed. The impetus for such suggestions is centered on the deteriorating conditions of the aging facility and the negative history associated with the Waterbury campus. Consumers, providers, and clinical staff cite the hospital as having conditions and an environment that is not conducive to effective treatment and positive recovery. The current facility, according to some, has the feel of a "jail" which makes it extremely difficult for patients to focus on recovery and not detention. Recent state psychiatric hospital construction in New Hampshire and Tennessee provides architectural models that create effective treatment settings for consumers who need services that will be provided by the new VSH. One major concern to note regarding this option is the limited ability to claim federal dollars.

Option #3: Create a regional hospital approach

The State could consider the feasibility of a regional facility approach when contemplating changes to the state hospital campus and location. Many stakeholders suggested that a viable alternative for the State was to not have one state hospital but have several smaller, regional state hospital facilities. Having these regional state hospital settings would provide easier geographic access for Vermonters (i.e. having three regional facilities spread across the northern, southern, and central parts of the State; or having two sites in the northern and southern or eastern and western parts of the state). These locations would facilitate integration with community services. The costs associated with establishing a regional state hospital system will be high, and the clinical staffing and management will be difficult to bear. The State will need to decide whether or not such an approach is financially feasible. One option, for example, is to locate VSH units at two or three local general hospitals.

Assessing the ability of these options to meet the criteria requires far more data than is currently available. For example, the specific partnership arrangements with general hospitals will have substantial impact on both costs and revenues. Further, the design and site selection for a new VSH will have considerable impact on integration with community care and access to general hospital services.

The following table presents the results of a preliminary assessment of how the options satisfy the criteria.

Preliminary Assessment of How the Options Satisfy the Criteria

Options	Criteria			
	New Design that Supports Treatment	General Hospital Access	Integrate with Community Mental Health System	Reduce Net State Cost
#1 Integrate VSH with a General Hospital	Medium	High	Medium	High
#2 Construct a New State Hospital Facility	High	Low-Medium	Medium	Low
#3 Create a Regional Hospital Approach	Medium	Medium-High	High	Low-Medium

This preliminary assessment indicates that more detail and data about potential partners, sites, and cost considerations will be necessary before Vermont makes a final decision.

2.2 DDMHS should conduct a feasibility study to determine the impact of specific site options, partners, and economic considerations against the criteria for a new state hospital.

While all three of the options could satisfy some or all of the criteria, it is clear that some will be more complete than others. A feasibility study will enable the State to apply its own criteria, values, and process for a new VSH against specific site options and partners. However, even an excellent new site will not meet the needs of patients who could benefit from community service. Needed community services include, but are not limited to:

- Long-term residential options for people who currently reside on the Brooks Rehabilitation Unit as well as for people who currently need or in the future will need long-term residential treatment care;
- step-down residential services that assist patients from VSH to return to community living more quickly;
- preventative types of services such as ACT and short-term crisis residential programs;

- psychiatrists and psychiatric nurses; and,
- Safe Havens.

3.0 Develop a Financial Strategy for the Community Services Needed to Reduce the Demand for VSH Services

The community system needs continued development to ensure that VSH is appropriately used for people who need secure, specialized, hospital level care. Although this study did not examine the adequacy of community services, the need for sustaining and expanding certain services became clear as we looked at the needs of certain persons who would use VSH. This leads to several recommendations in support of developing expanded community services.

3.1 DDMHS should develop long-term, secure community residential service options to meet the needs of persons who currently use 10-12 VSH beds located on the Brooks Rehabilitation Unit.

These services would be appropriate for patients who resided on the Brooks Rehabilitation Unit at the time of the PCG review. This group of patients has a diverse range of diagnoses which includes, but not limited to, character disorder. Planning for these services will need to take into account the cost and potential revenue for residential care, crisis services, case management, and re-hospitalization.

3.2 Each Community Mental Health Center should have a full-time liaison assigned to work with VSH to ensure proper communication and coordination of services.

The impact of effective liaison work between VSH and the community will be shorter lengths of stay, and, possibly, reductions in bed utilization at VSH.

3.3 The small size of VSH requires new resources to meet these needs; reallocation of VSH resources to the community is not economically feasible.

When large state hospitals phase down, it is desirable to determine how the cost of inpatient resources can be reassigned to support community services. The small size of VSH and the intense service needs of its patients do not make this a practical financing strategy.

4.0 Other Recommendations for Consideration

Currently, DDMHS has a System of Care Plan and a Adult Mental Health State Program Standing Committee, both of which can be key parts in addressing the recommendations which are included in this section. The System of Care Plan can be revised and expanded to become a more complete "blueprint" for the Vermont mental health

system. The Adult Mental Health State Program Standing Committee should be actively involved in the development of the Plan revisions.. Areas to be addressed include the following:

- DDMHS and the Department of Corrections need to engage in a collaborative planning process for providing mental health services to populations that are served in common by the two departments. The goal of this collaborative planning process should be focused on providing the highest quality of care in the most effective manner possible. The process will need to address components such as facility needs, program requirements, financing and responsibility.

- DDMHS should assess its organizational structure, roles, and responsibilities to ensure that staff are protected from potential conflicts of interest as the Department serves as the payer, provider, and licenser of mental health services. The results of this assessment should be widely communicated along with any protocols developed.

- There should be a clarification of roles and responsibilities with the legal system to ensure that the system effectively and efficiently meets the needs of people with mental illness who access the Vermont public mental health system. This would involve a review of the roles of the DDMHS Legal Unit, Vermont Legal Aid, and Vermont Protection and Advocacy all of whom currently serve staff, patients at VSH, and in some cases patients' family members, at VSH.

- There should be an improved process for determining where court-ordered evaluations are appropriately performed based on diagnostic characteristics. Additionally, the process should be strictly monitored to ensure adherence to the protocol.

- Treatment for patients who refuse medication should be ensured. It is our understanding that a protocol has been developed, with extensive stakeholder involvement, to address implementation of Act 114 at VSH and at the designated hospitals. However, based on input received, this protocol/implementation process is not well understood or has not been made readily or easily available to stakeholders. Steps should be taken to ensure it is better communicated.

- Develop a consistent, system-wide approach for communication, which occurs in a reciprocal fashion among VSH, the designated hospitals, and the community mental health system for the purpose of enhancing the quality and continuity of services provided.

- Ensure that the mental health laws for the State of Vermont are organized and available in such a way that they are easily understood and accessible to all interested stakeholders.

IX. Appendix A: Survey of Vermont State Hospital and Mental Health System Stakeholders

The following pages contain summaries of statewide stakeholder meetings PCG facilitated with Vermonters involved with or impacted by the mental health system and VSH. The purpose of these meetings was to develop an understanding of: a) the current role and function of VSH within the continuum of care; b) who is being served at VSH; c) the role and function of the particular focus group; and, d) the relationship between VSH and the rest of Vermont's mental health system.

Over the course of the study, PCG met with over 200 individuals. No DDMHS officials attended these meetings in order to ensure that stakeholders spoke candidly of the issues facing both the system and the State. Additionally, feedback from 13 stakeholders was obtained through the project email address. Participants in the stakeholder meetings were promised anonymity in that their specific names would not be used in this report.

It is important to note that the following comments do not necessarily reflect shared viewpoints of the individuals who participated in group meetings, and may only represent the viewpoint of one of the participants. In addition, we have not attempted to correct any factual inaccuracies that may have been expressed by the participants as the following is intended to present the perceptions and experiences of the various stakeholders regarding VSH.

The following pages highlight major findings from these stakeholder interviews and focus groups.

1. Designated Hospitals

PCG met with 43 individuals at the five of Vermont designated hospitals. This group included clinicians, administrators, and other staff. The hospitals visited were the Windham Center, Central Vermont Medical Center, Fletcher Allen Health Care, Rutland Regional Medical Center, and the Brattleboro Retreat.

There are a variety of patient populations that need to be served at VSH. The designated hospitals try to serve as many "difficult" consumer populations as possible. However, there are limitations to what the staff (i.e. training and experience) and the facilities (i.e. space, resources, security) see as their mission. VSH needs to exist in order to provide a setting where these populations can be served. These populations and services include forensic evaluations, consumers refusing medications, borderline personality disorders, aggressive / violent patients, chronic medication refusers, patients with trauma histories, and consumers that one hospital noted as a "unit-clearer" (defined as more aggressive patients who harass other patients on the floor and eventually drive them to discharge themselves due to discomfort with the treatment setting).

There is a distinct need for VSH as a "safety valve" for the designated hospitals and the

community providers. The designated hospitals attempt to serve more difficult populations knowing that they can shift these patients to VSH if they find them to be unmanageable at the community level. If VSH did not exist as a safety net, the designated hospitals would "screen out" many of the "gray area" patients that they currently admit and attempt to treat. Designated hospitals and the community providers are not equipped to manage highly aggressive individuals and people who refuse medical intervention. More importantly, VSH provides a level of protection for certain patients that the designated hospitals and community providers cannot serve.

VSH is a critical element within the continuum of care. VSH needs to exist in order to ensure that the proper and full continuum of care is in place. There needs to be a strong state hospital in order for the community system to work.

Changes to the VSH physical plant should be considered. VSH should be viewed as a "hospital", not just as a "state hospital". It should be providing good services to anyone who needs them. Many people within the system perceive VSH as currently serving three functions – acute, residential, and custodial care. The state does not necessarily need one hospital to do all this. One suggestion is to have two state hospital sites and to split these sites geographically. Another suggestion is to have three smaller facilities that each serves one of the above mentioned three functions.

State laws regarding involuntary treatment have been problematic for the designated hospitals. Designated hospitals find it difficult to contain individuals who are refusing treatment and provision of "custodial care" is felt to be generally disruptive to the milieu. This is exacerbated by what the designated hospitals consider the slow pace and foreign process of the court system as it attempts to deal with individuals refusing treatment.

Communication between VSH and the designated hospitals needs to improve. Some see the relationship with VSH as being adversarial. There needs to be a collaborative sense amongst designated hospitals and CMHCs that they are part of a system and not their own independent islands of care. Folks in the community have lost the "partner" feeling they used to have with the State and believe it is critical to find ways to get it back.

Where there is not one in place already, catchment areas should establish a liaison position with VSH. In instances where a community liaison to VSH was in place, there was a more positive and effective relationship between the state and community levels. Designated hospitals believe that the liaison with VSH helps to ensure a smooth transition for patients from VSH into the community system and vice versa. The liaison provides the catchment areas with someone to sustain regular and frequent communication with the hospital.

The recent problems at VSH have brought about feelings of betrayal and distrust amongst the designated hospitals and the community providers. Given the level of the state's oversight of the community level of care, it was unsettling for the designated hospitals and CMHCs to find out that the state was not holding itself subject to the same

scrutiny. Designated hospitals and CMHCs feel that there is a double standard in place and that the current system of oversight is designed to perpetuate more oversight.

The legal system creates an unpredictable environment, difficult for consumers and the community system to negotiate. Court hearings are lengthy and often times delayed for significant periods of time and forensic evaluations take too long to complete. In addition, the courts and judges need to be better educated about the mental health system. Some folks are of the mindset that the legal system is never going to change and the mental health system needs to accommodate its downfalls.

Steps should be taken to develop a new model of forensic care. Several people at the designated hospitals noted that they would like to work on a model of care for forensic consumers such as a "Legal Unit." This unit would address the legal complications some patients have. It would consist of legal and psychiatric staff in order to provide best possible care. This approach would help foster a strong working relationship between clinical and legal staff. (There is a perceived rift between legal and psychiatric staff, which is problematic when serving some of the same population.) The unit would also address the length of time it takes to evaluate forensic patients at designated hospitals and CMHCs, which is one of the major complaints.

The designated hospitals and CMHCs feel that the State reached the current bed number without much logic. The current number of beds is seen as very arbitrary and fiscally driven. It goes against Vermont's historical innovative trend of placing people appropriately in the community.

Increases in unconventional patient populations are straining the community. There are increasing numbers of younger patients with co-occurring disorders as well as older patients with physical health problems. These populations need to be addressed in addition to the general mental illness population. Nursing homes won't take this population.

Vermont needs to invest more resources into the community system in order to enhance/improve good services already in place. Current gaps in community resources result in delayed discharge of patients. Supervised residential (half-way) services and supported housing for individuals to step down to are most critically needed, but availability of psychiatric outpatient services is a major gap in more rural communities. In addition, the community system is struggling because many workers migrate to the state system because of better pay and benefits.

DDMHS needs to be the leader of the Vermont mental health system. The state has been a national leader in mental health care. The state needs to respond to the recent troubles at the state hospital by leading VSH and the entire system into the future.

2. Adult Mental Health State Program Standing Committee

During this visit, PCG project members met with eight individuals from the AMHSP Standing Committee. The Committee was formed as an advisory group by state regulation, and has been meeting for the past several years.

Allocation of resources is an issue. The State should be careful not to solve the problems at VSH by simply taking resources from the community. Any shift of resources from the community to VSH would increase an already problematic imbalance.

There needs to be an improved, shared vision between VSH and the community system. VSH needs to serve consumers that the community system cannot or will not serve. A seamless recovery vision needs to be in place that spans all staff and all facilities in Vermont. One necessary outcome of this study is a statewide plan that the state hospital and community system can both follow.

The continuum of Vermont mental health care system needs to focus more on trauma. The entire system – not just VSH – needs to become "trauma competent". The treatment provided to consumers needs to be administered with sensitivity to trauma histories and trauma needs.

The designated hospital system has been successful. There used to be a feeling amongst the designated hospital providers that VSH was not around the same table with the designated hospitals. Incorporating designated hospitals into the system and carving out more of a role in conjunction with VSH would allow for better integrated treatment for all Vermonters.

The community system is underserved and resources are lacking. Intake appointments at community providers are on a two-month delay and other consumers cannot be discharged from hospitals because of a lack of services. Housing availability and staffing resources should be improved. There are a lot of good options in the community but not enough of them. No matter what is done to fix VSH, if the state does not give attention to the other elements of the system, you aren't going to change a thing.

A new physical and clinical structure for VSH should be considered. Having a state hospital is necessary but it needs to evolve from where it is today. The facility needs to be more than just a "warehouse". Given the increasing physical health ailments of the aging mental health population, perhaps the system should work towards integrated treatment (mental illness treatment with medical treatment) by attaching the state hospital to a general hospital. Another way to better serve Vermont consumers may be to develop regional state hospitals. In each instance, the forensic unit could be moved to another facility.

The continuum of care should include a liaison to VSH for designated hospitals. Establishing liaisons to VSH will improve the lines of communication between the designated hospitals and will help ensure that consumers admitted to and discharged from VSH will receive appropriate levels of care.

Treatment and support for families of the mentally ill should be a high priority. While the focus of a mental health system is to address the needs to the individuals with mental illness, there should be a way to provide much-needed support to the families of

these consumers. The state needs to think through how this can be accomplished.

Two growing populations include the elder consumers who are developing medical needs, and new admissions to the system (first time experiences with mental health issues). The state hospital and community systems need to address ways in which the needs to these two growing populations can be met by Vermont.

3. *Community Diversion & Step-Down Programs*

During site visits to three community alternatives, PCG project members met with eleven individuals, both providers and consumers. PCG visited Next Door (step-down program), Home Intervention Program (hospital diversion), and Safe Haven Residential Program (peer outreach).

There is a definite need for VSH, or at least facilities like it which provide a comparable level of care. A distributed system of multiple "state hospital facilities" would be more costly but would be more humane. The state needs this level of care somewhere within the system. One certainty is that a better facility and better physical plant is needed.

The emphasis at VSH, and system wide, should be on the "out-route". There is too much of a focus on admissions. VSH and the system should be able to take more people in but should focus on getting better at moving people out. Solving the problems with discharging patients is key to resolving front-end efficiency problems at facilities. The system cannot admit any consumers unless it is treating and releasing them effectively.

The legal system needs to be fixed. Steps should be taken to pull together a group of advocates, care providers, and legal people to iron out how the system could be reformed and revised to best need the mental health needs of consumers. The courts are not knowledgeable enough around consumer needs and the court process works too slowly to address needs in a timely fashion.

Civil and forensic beds can co-exist in the same physical plant. The issue is not separating these two populations but ensuring that VSH provides the adequate level of safety and security for each population. Currently, VSH does not provide this level of safety and security.

There is no statewide agency or program that coordinates all of the community and residential housing programs. Doing so would help foster a more effective system of moving consumers from the state hospital to the community setting, and vice versa. Consumer care would be more fluid and appropriate care settings would be found.

Treating the aging population with mental illness who begin to have physical health problems has become a significant issue. A big problem arises with consumers who need to be moved into nursing home care, but nursing homes will not touch people with major psychiatric disorders.

There needs to be more community diversion and step-down programs. There is a significant shortage of this facility type in the community system. More specifically,

there always seems to be a waiting list to get into Safe Haven. The demand for this type of facility is extremely high. There needs to be another Safe Haven with daytime staffing (not 24-hour) to provide step-down in the community. This would be a big asset to the system. The presence of another Safe Haven would reduce recidivism to VSH and the consumer's need to start from scratch again at Safe Haven. These facilities help consumers transition back into the community.

Some consumers are stabilized by pre-placement visits and short visits. This approach allows consumers to participate in community settings while still technically a patient at VSH. This process helps stabilize treatment and provide a smooth transition of care.

4. ***Council of Mental Health & Substance Abuse Professionals***

During this visit, PCG project members met with nine individuals.

The resources available to the community system need to be increased. There are not enough community homes available. Increasing the number of community homes will relive some of the strain on VSH resources and staff. People served through the CRT Program need more resources as well. The most difficult populations need to be served at VSH and the designated hospitals. The private sector is not interested in taking the difficult clients served by VSH because it does not have the resources to manage these populations.

The system needs to adjust to dealing with the aging consumer population. An increasing problem facing the system is the aging population that is beginning to have medical problems. Ways need to be devised to treat the mental illness and medical problems of these individuals.

Vermont's broad parity has been backfiring. The state has the reputation of having some of the broadest parity laws in the nation, but these laws have begun to strain the system.

Act 114 is problematic. Act 114 has made it difficult to treat consumers at VSH and elsewhere within the system. Some consumers need involuntary treatment but it should not be punitive or irresponsible.

Forensic patients at VSH should be separate from the civil commitment patients. Mixing these two populations at VSH creates an ineffective treatment setting. Both populations would be better served in separate locations.

Consumers at VSH deserve the best care possible but are not receiving it. The state and community need to find a way to provide the best and most appropriate care to those residing at VSH. Part of the problem is that the mental health system is not a seamless system but needs to be. One way to help achieve better care is to separate the acute and residential functions of VSH and develop a viable alternative to the state hospital.

There is an effort within the community system right now to improve dual-diagnosis treatment. It would be good to have VSH involved with such an effort. Collaboration

would help improve the continuum of care.

5. Community Rehabilitation & Treatment (CRT) Program Directors

During this visit, PCG project staff met with eleven individuals.

VSH has been out of the loop. The state hospital has not been a partner with the community system. It is disconnected from treatment planning of community service settings. Refusing to resolve arguments that have taken place over the years has isolated VSH from the community.

The old monthly forums with VSH were never effective. No VSH representatives ever came to CRT meetings and CRT directors were always left in the position to resolve everything at and with VSH.

DDMHS should consider new ways to use VSH and the Waterbury campus. One suggestion is for DDMHS to work closer with the Department of Corrections in order to get out of the involuntary care business. Another would be to set-up a group home on the VSH campus in order to provide the custodial care that some VSH consumers need. DDMHS should also rethink the Medical Model in place at VSH. This model bumps heads with what the treatment approach used by the community system. For a state with one of the best community systems, it's shocking to see how poorly VSH is running.

The resources available in the community are lacking. CRT Programs are asked to do more with less. The amount of money invested in the community system is only getting worse. There should be resources to set up a joint CRT-VSH treatment team. In addition, the future mental health system needs to have another level of care such as a long term residential facility for people that d not require 24-hour supervision.

VSH should make sure that it serves specific target populations. Populations that need to be served by VSH should include the following: trauma, borderline personality disorder, aggressive behavior, patients requiring 24/7 supervision, and patients who refuse treatment. These consumers have been generally shut out of the community system and have no place to go other than VSH. Nobody outside of VSH is stepping up to serve this population.

6. Vermont Association of Hospitals & Health Systems (Mental Health Inpatient Group)

During this visit, PCG project members met with eight stakeholders.

VSH should perform the role as a safety valve. VSH need to be the facility that treats consumers the designated community hospitals are unable to serve. Instances when this happen includes non-compliance with medication or treatment

VSH needs to become a proactive treatment setting as opposed to a reactive treatment setting. It is currently a place that builds to crisis and then reacts. Instead, VSH needs to take a proactive approach to diverting individuals from placement there.

VSH needs to develop the capacity to assess and monitor medical status. The hospital also needs to develop a "better" system for accessing needed medical care (i.e. transporting / distance issues).

DDMHS needs to function more cooperatively and provide more collaborative leadership within the mental health system. There is no planning as a system on the part of the Department. It views the private hospitals, the state facility and the community system as a collective but there is no common agenda. The Department tends to be controlling, not facilitative. The vagueness of the Department contributes to the silo mentality of operation. In addition, the Department micro-manages the designated hospitals. Rules and policies are developed and rarely written.
DDMHS has a conflicting role of funder, regulator, and provider. Being in these three roles prevents the Department from advocating for individuals.

DDMHS is overstaffed and top heavy. More regulators are hired when clinical staff and services in the community are cut. The dollars spent on this infrastructure should be reallocated to services, not administrators. In addition, the Department needs to have staff that has clinical training and program expertise.

The forensic population could, and should, be served by the Department of Corrections and the criminal justice system.

Legal issues around refusal of treatment and orders of non-hospitalization require significant attention. DDMHS needs to review the various components of the issue such as timing, context, and implementation, as well as

There is no written Mental Health Code. This is an integral part of the mental health system that needs to be addressed.

Funding is inadequate for serving higher acuity consumers. This can be seen by looking at practice standards in comparison to resources.

Issue with code / laws should be reviewed in the context of the system, not the professionals versus the consumers. Vermont codes and laws should be compared and contrasted to those of other states. Best practices and setting benchmarks for quality service delivery should also be looked at.

The manner in which mental health patients are screened due to Medicaid requirements is a barrier to access. The de-medicalization of the mental health system serves no clinical purpose.

The forensic population should be served by Department of Corrections. The new prison has a designated mental health block. It is important to separate criminalization of mental health from acute mental health needs.

The designated hospital system functions reasonably well and they have leverage which could be used to improve the system if financial and systems changes were not

forthcoming. This system could serve as an infrastructure for services to many of the populations currently served at VSH. Given the latitude and resources they could serve anyone, but resources are key.

Acute patients could be treated at community hospitals. To do so, funding and legal issues need to be addressed.

Long-term residential services need to be developed; locked community services could be developed as well.

A more effective and efficient judicial system needs to be developed. The Acute Care Team is a failure and dollars that fund this team could be reinvested in a judicial system that works.

Regional capacity could be developed to treat higher acuity patients. Issues that need to be addressed include: resources, critical volume and adequate space to house diverse populations.

Incentives should be provided to Psychiatrists who work in rural areas of the state.

7. Vermont Coalition for Disability Rights

PCG spoke with this one individual via conference call.

The current VSH physical plant must be abandoned. VSH is too troubled clinically, financially, programmatically, and physically. In addition, oversight is too obtuse. To expend further resources on this facility would be a waste of dollars and is also not possible.

All options have not been explored. There is agreement on the concept that there are two populations (clinical and forensic), and within forensic there are two sub-populations (observation / evaluation and criminal / long term). The current population should be divided into these sub-categories and decisions on future treatment and place served made on that basis.

A regional facility approach needs to be considered. A single facility in any one part of the state would be the wrong path to take. Some people are at VSH only because their communities will not accept them (NIMBY). Vision of a regional system should be given strong consideration. Whatever is developed needs to be geographically disbursed; Waterbury could certainly be the site for one of the small programs but not on the current VSH campus.

Legal supports system in the designated hospitals does not exist. Civil rights practices are poor. The mental health law project only operates at VSH. Whatever alternative is presented it is suggested that the legal component will need to be well-structured seeing it only works marginally right now.

The State Board of Mental Health is still on the books but does not function.

VSH operates as an appendage to DDMHS. There is no consumer oversight even though all the other divisions within the department have consumer oversight. Thought needs to be given to the development of a regular oversight body.

Budgetary pressure within the mental health and developmental disabilities systems is overwhelming. Each system has taken significant budget cuts over the last five years.

There has always been a murmur of discontent from consumers at VSH but the voice was not large and it took a tragedy or two to be heard.

8. Hospital and Community Psychiatrists

During this visit, PCG project members met with sixteen individuals.

There is pressure to get people out of the community hospital. The culture in Vermont seems to have switched to one where general hospitals are inclined to push people out of the hospital as opposed to waiting until the appropriate community placement is available.

The legal system is too cumbersome and too complex. The court system is slow in hearing cases and dealing with the timeliness and complexities of mental health issues.

Administrative rules require extensive paperwork on behalf of people served in the CRT Program. Paperwork takes roughly a month to process which places a significant strain on the admissions process to CRT programs.

There is a trend of decreasing funds for mental health services across the board. Currently, there are insufficient dollars for follow-up care. Many are worried that this lack of resources will lead to deterioration of the community system.

There is a trend of criminalization of people with mental illness. Many consumers are sitting in the criminal justice system that probably would be better served in the mental health system.

The census of VSH is filled substantially by forensic patients. One-third of VSH population is there because of court orders. This population is counted against the county bed day allocation and is consuming valuable resources that could be used for civil commitments.

There is a trend surrounding the right to refuse treatment. Roughly one-third of the people at VSH refuse treatment. Because of this treatment refusal, the state loses federal reimbursement that it would otherwise receive. The federal government will not pay for this population but Vermont statute mandates no involuntary treatment. This has become a significant problem and sizable political issue.

Psychiatrists are tired of feeling unsupported by DDMHS. They feel that clinicians and clinical staff have the best interest of patients at hand as much as the advocates do,

perhaps more sometimes. However, clinical staff feels as though they are constantly on the receiving end of criticism.

The court system is not the appropriate system to determine treatment for consumers. The court system as a whole should not have as much say as it does in determining treatment because of inefficiency of the rules of evidence and process. There should be a mechanism in place, that isn't the court system, which determines treatment for forensic and involuntary cases. Changing the role of the court system, such as the idea for a mental health court has been circulated but has not been broadly discussed in a serious manner.

The nomenclature of "mental illness" versus "mental health" is troublesome. The state needs to admit that disease exists and acknowledge the people who need treatment. The drive to keep people out of hospitals has deteriorated the treatment process.

The state is failing its most seriously ill folks. Consumers refusing involuntary treatment are not being served. If treatment does happen, it takes too long. The state does not have any other venue outside of VSH where this population can reside.

VSH currently serves three distinct populations: 1) patients with mental illness who are criminally incarcerated, 2) aggressive / violent / dangerous patients, and 3) refractory patients who are still impaired regardless of receiving the best possible treatment. One possible solution is to try and have separate facilities that serves these three different populations. This surfaces the debate around a central state hospital versus community hospitals.

The physical plant size of VSH is too small. The aggressive and non-aggressive patients live in close quarters. This is detrimental to the healing process.

VSH has never had the flexibility to sort through its variety of consumers. VSH needs flexible capacity and fluid give-and-take with the populations.

There is a trend of increasing consumers with organic mental illness. The distinction between organic and functional mental illness is quickly fading across the state.

Durable power of attorney and order of non-hospitalization have been presenting conflicting and controversial situations to the mental health system.

9. Vermont Association for Mental Health

During this visit, PCG project members met with two individuals (the Executive Director, and a Board member).

A new level of accountability and defined oversight needs to be established by the State. The current level of oversight is reasonable (i.e. Standing Committees). However, a new level of accountability and oversight needs to be formulated for the current operation of VSH as well as for any possible model for integrating VSH services into other treatment settings across the state (i.e. regional hospitals, new facilities, community mental health

centers). All Vermont stakeholders need to be engaged and accountable.

The VSH physical plant is inadequate, perhaps archaic. The grim setting and structure of the hospital quite possibly prevents the provision of state of the art treatment. It would be difficult, if not impossible, to provide a positive therapeutic environment for VSH consumers. Three alternatives to VSH include: 1) major renovations of the current site; 2) utilization of other facilities (i.e. regional hospitals); 3) or construction of a new specialized state unit.

The mix of populations at VSH presents great challenges. VSH has increasingly dealt with more seriously ill consumers. The current setting at VSH mixes forensic consumers with non-forensic consumers. Vermont needs to explore whether or not it has the appropriate clinical strategies to serve these two populations, especially given the limits presented by the current physical plant.

More thought needs to occur around involuntary treatment. Fortunately, Vermont's long term goal is to eliminate involuntary treatment for psychiatric patients. However, the state needs to figure out how to best serve its mental health consumers who refuse treatment. Involuntary treatment is still part of the current system, and more thought needs to occur around developing good clinical intervention models for all consumers, including ones who enter the state system involuntarily.

There needs to be more attention paid to "best practices". Vermont can and should do better job identifying "best practices" designed to treat individuals with mental illness in the hospital setting. "Best practices" should not be limited to clinical care. This should also apply to legal representation, grievance protection, and environmental standards. Hopefully, agreement can occur around all "best practices" for Vermonters with mental health needs.

Parity needs to be a major focus when rethinking the Vermont mental health system. The current VSH setting isolates and segregates individuals with severe psychiatric conditions from the rest of the Vermont community. Placing these consumers in a rural Waterbury farm setting is questionable practice. The current guiding principle in the state around combining physical and behavioral health care should be at the forefront when rethinking the structure of the public mental health system and the role of the state hospital. One recommended approach is the integration of clinical practice, community access, and, perhaps, physical integration in facilities that are part of the community-based health care system.

10. Vermont Developmental Services Directors

During this visit, PCG project members met with thirteen individuals.

VSH needs to be a safe and secure setting on a temporary basis for individuals who can't be managed in the community. This type of service is provided only marginally for consumers with developmental disabilities.

VSH needs to see itself as a short-term solution. This may be the biggest hurdle facing

the system given that VSH does not see itself as serving this function. Currently, there is no such philosophy but one needs to be implemented.

Consumers with developmental disabilities cannot gain admission to VSH. This makes certain community situations much more difficult to manage. VSH needs to better understand that people with developmental disabilities have mental health needs as well. This particular population does not have the same access to VSH that consumers with mental health do. The hospital needs to abandon the attitude that staff are not trained to deal with this population, which is a common justification provided to the developmental disabilities system. Even if people with developmental disabilities get in to VSH, they are ushered out immediately, or request the counties to staff the person with developmental disabilities in VSH themselves. Ultimately, there needs to be different strategies implemented at VSH to better serve people with developmental disabilities.

There are three functions of VSH that may be done better at another facility or multiple facilities. DDMHS should look at alternate settings that can provide: (a) forensic services, (b) long-term, and(c) acute commitments.

Fixing the current problems at VSH is neither possible nor the most cost-effective option. The problems at VSH are too complex and attached to the institution. The stigma around VSH cultivates the current issues. Simply looking at the current facility and making changes will not help.

There is a stronger relationship with the designated hospitals than with VSH. The developmental services system rarely uses VSH. However, the system frequently works with the designated hospitals to treat the mental health needs of developmental disabilities consumers.

The improvement of VSH resources cannot be done at the expense of the community system. The community system is already stretched thin in terms of the services it can provide and the number of consumers it can serve. If the state were to use community resources to resolve the issues at VSH, similar problems would arise within the community system.

The safety net for Vermont consumers needs to be the community system. The mission and strategy at VSH needs to be altered so the hospital can function in a way that supports this approach.

The stigma attached to VSH inhibits potential good treatment that the facility could offer. If VSH was not seen as a “dumping ground” and did not carry decades of stigma in the eyes of consumers, it could be part of a viable treatment option and continuum of care.

11. Vermont State Employees Association Staff

PCG project team members met with four individuals via a conference call.

The VSH physical plant presents a host of treatment limitations and complexities. The physical plant has been an issue for many years and was a problem that should not have been a surprise to the people who are now complaining about it. Individuals in positions of authority have let VSH slip into its current condition. The current facility needs improvements that will help foster a better treatment setting for patients and staff alike.

There is a serious concern that VSH has become the target for groups looking for ways to fund their own program(s). The Association believes that there has been substantial finger-pointing at VSH by the community system. As competition for funding becomes more intense, the community will continue to attest that it can treat VSH patient when in all reality that is not the case. Vermonters with critical mental illness needs are admitted to VSH only after it has been determined that none of the other eligible facilities (i.e. designated hospitals) can provide adequate and appropriate treatment. (This determination is made by the other facilities.)

VSH has accountability. The tax payers have accountability of the state hospital. Community mental health providers, on the other hand, do not have any accountability to the tax payers. Community providers have been sending proposals to the state legislature on how they can take on the VSH population. One reason this would be detrimental to the state is that Vermont need to have a state hospital system in place that is accountable to the governor, the system, & the tax payers. The Community system does not provide this.

Community mental health centers are significantly strained. The community system is stretched so thin that patients are much sicker when they get to VSH. VSH provides the best level of care in the state. Privatizing the state hospital services would be biggest disservice to patients, family members, state employees, and the state mental health system as a whole.

It is frustrating to hear claims that other facilities can provide treatment identical to that at VSH. None of the other designated hospitals can handle the complex needs of the VSH population. The community system in Vermont does a very good job at treating the consumers in its care, but does not deal with same consumer population as VSH. Consequently, the community system's staff and cannot do the same job and provide the same services. Community facilities would have to be retrofitted to take the VSH population. More money would have to be poured into the community system to provide the same services as VSH than it would probably take to address the current problems at the state hospital.

The talk of closing VSH is very frustrating. The state should not dole out VSH to the community system. The problems at VSH happen outside of VSH; it is just that no one looks at it. If VSH was to shine the same spotlight on community system or other designated hospitals, there would be plenty of deficiencies. People at the local levels do

not understand what they would be dealing with in terms of the complex population, the number of assaults on staff, and staff injuries. In addition, there is a misimpression that there is great support from the governor's office and the legislature that VSH needs to close. There will be some serious debates when the issue comes to a head because many people do not think it is a good idea to close down the state hospital. Creating more space, a new facility, or a more therapeutic milieu would be the best options to pursue for VSH and the entire state.

VSH serves a population that no one else wants or can provide care for. If VSH closes, the population is not going to disappear. These consumers will be forced to the streets or to jail. They will not be served by the community system, given their complex needs.

VSH staff has strong commitment to their jobs despite being understaffed and underpaid. For years, VSH staff has endured being overworked and underpaid. The pay needs to be commensurate with work done, and need to have more staff available to work.

The forensic population can be managed at VSH. Court-ordered evaluations for those who have committed crimes are placed at VSH into the general population of patients who have not committed crimes. Doing so places civil consumers in danger. The same occurs with misdemeanors. However, as long as the forensic population is not posing threat to others, then there is no problem. If they are posing a risk to themselves, others, or have assaultive behavior, it is a problem. A specialized unit would be beneficial for populations with assaultive behaviors. This special unit could be created at the current VSH as opposed to the Department of Corrections. DOC is currently facing its own problems with its "mental health system". Individuals with mental illness are suffering under the care of corrections. It would be extremely punitive to place mental health consumers in a correctional facility or under the management of a correctional facility. The state needs to avoid this punitive action at all costs.

VSH needs to continue the steps it has taken with Act 114. The VSH staff has really worked hard to engage consumers to participate in the treatment process. Vermonters have the right to refuse treatment, but it poses a problem when trying to claim Medicaid dollars. This is part of the current dilemma. The statute will not change whether patients are at VSH, some other facility, or in the community system.

12. Vermont State Hospital Activity Therapists

PCG staff met via conference call with four occupational activity therapy staff from the state hospital.

VSH should continue to serve its current population. The state hospital should continue to serve the most extremely mentally ill consumers across the state. These are individuals who cannot go anywhere else in the system because the level of needed care does not exist.

Forensic beds should be handled by the criminal system. VSH should be used primarily for individuals with mental illness. The presence of forensic beds at the state hospital

sometimes results in individuals residing at VSH whose primary problem is criminal behavior and not mental illness.

The number of community programs needs to increase. There is a perception that not enough community programs exist for individuals transitioning out of VSH. The activity therapists are not interfaced with the community system other than that their main job is to prepare VSH patients for functioning within the community system. A lack of staffing is one of the major reasons for the lack of community programs. Steps need to be taken to ensure that there is an adequate level of community programs and work shops.

The state should explore the possibility of providing educational opportunities for VSH patients. Several long-term patients at VSH have been asking the therapists about the opportunity to partake in continuing education work either at the state hospital or in the community. Doing so would be another way to better transition consumers into the community.

13. Vermont Council of Developmental and Mental Health Services

During this visit, a PCG project member met with twenty individuals who were service providers and executive directors.

A vision for VSH is the wrong place to start. The systems of care needs to be looked at first. Consumers spend at least 70% of their time in communities not at VSH.

The State is amidst a role conflict and does not hold itself accountable. The State currently functions as the payer, regulator, and provider. It does not perform these three roles well and at a minimum should give up the regulator role. The department micromanages the community services and designated hospitals through regulatory control instead of focusing on outcomes; the client is last not first.

CMHCs are not uniformly funded to provide Assertive Community Treatment (ACT) teams. The lack of ACT teams presents a continuity of care issue.

VSH does not do joint treatment planning or use an integrated approach to treatment planning or discharge. Discharge treatment plans from VSH, have no relevancy to community services.

There needs to be a connection between VSH and the community system. VSH today is no different than the VSH that served 1,200 people. There is still no connection to community systems of treatment. The state needs to create a system of community mental health services-this is the Vermont value that is foundational to the system. Case rate system created the isolation of VSH from the community system.

VSH is the place people go when the community system cannot treat them. Many community service providers serve people who are just as intensive as or more intensive than those served at VSH. If these populations cannot be served in the community setting, they are sent to VSH.

Fixing VSH should not be an option; it is not fixable. The problems at VSH currently are too deep and too many to fix. For instance, the physical condition of VSH is not safe and there is not enough money to fix it. Fixing VSH is not a priority for a system that has limited financial resources and many needs.

The State should conduct a statewide assessment of the community mental health system. Community services face quality of care issues too. Community services are not accredited so the ramifications are different than those for VSH but they are just an inch way from serious problems occurring such as suicides, etc. Over the last 3-5 years, the community system has been decaying; there has also been a collapse of services for persons with SA, SPMI, and developmental needs. Community staff are underpaid (as much as 25% less than VSH staff), benefits are poor, and the clinical capacity to appropriately serve people becoming is harder and harder to access. A look at the entire system needs to occur across services, populations, and facilities.

The previous vision of VSH was to close it and there has been nothing beyond that communicated. The vision was more of a political statement than a statement that promoted a system of care and required planning. The motivation was to save money not shift funding to community services. Funding was shifted to the community with the developmental disability facility closure.

There is a need for a secure facility for persons who have mental health needs and need to be incarcerated. Community providers have no control over the judicial process but are penalized for over utilization of VSH. VSH has become the de facto prison for persons who are a threat to community safety. Long term care or extended care is needed.

Fixing VSH cannot mean cost shifting from the community services to do so will further complicate the fiscal viability of these community agencies.

Do not lose the preferred provider system in Vermont. This system has served the state well due to the state's population and geography. It is the best system for now; it has economically assured continuity of care. Administrative costs are very low. Issues of bigger being better do not apply to Vermont.

Vermont has a common set of values and principles and one of these is local control, community ownership is invaluable. Removal of this role brings a number of negatives, both tangible and intangible. Local care practices that have developed through relationship building are essential.

Continuation of external review of VSH needs to continue and be strengthened. This should include consumer involvement in at least an advisory capacity. Ultimately, there needs to be a governance structure.

There is no existing Mental Health Code. DDMHS and the state need to review the current rules and regulations and develop a detailed mental health code.

Forensics should be handled by corrections.

Locked care in the community needs to be developed.

Designated hospitals' capacity is not full utilized until a crisis at VSH exists.

The report from this study must be viewed as viable tool for the state to use. The expectation is that recommendations will be implemented. The report cannot just turn out to be a report that the department can shelf and disassociate from. The study needs to be used to promote the needed changes. The report should include options on implementation issues from which the legislature can select.

Currently, a liaison with the community services is non-existent. Some liaison work is in place as a result of individual effort of particular areas of the state but it is not a part of a systems approach. The liaison role could go a long way in solidifying the continuity of care and collaboration amongst components of the system. It is an upfront investment but would save dollars in the long run. Community services need to be funded to have a liaison also. These liaisons would help lead to an integrated treatment planning approach.

The current challenges facing VSH staff should be addressed. Staff at VSH needs training on clinical and treatment practices. Salary and benefit disparities between VSH and community services are huge. VSH staff should be allowed to follow patients into the community to assure smooth transitions and, likewise, community staff should follow people into VSH.

Treatment at VSH is heavily focused on psychiatrist-only care. Other staff just implements or follows instructions. Community services use a treatment team approach and all team member's roles are important and valued.

Funding mechanisms at VSH, as well as the community, do not support an integrated team approach. Under the behavioral health managed care plan emergency services for mental health treatment are not funded, but physical health emergency treatment is funded.

Despite the current problems at VSH, there are some quality practices and services at VSH. The hospital provides value to some consumers who want to go there because the constraints on acceptable behavior are broader / more permissive. If this type of care was pushed to the designated hospitals it would marginalize these individuals.

"Creaming" and cherry-picking does happen at the Designated Hospitals. This occurs due to the regulatory oversight and payment rates. An average case rate does not support taking risks. The designated hospital's services start with a discharge mentality this is not the case at VSH.

A broader health focus is needed at VSH but the current physical plant is not set up to

do so. Access to medical care or even evaluation and monitoring is not feasible in the current environment. Even some designated hospitals have shortcomings in this area. The role of the medical staff at VSH is not well defined.

VSH tends to change meds when a person is admitted with little or no regard to or for what had gone on in the community. Transitions from the community system to VSH, and vice versa, need to be done in a manner that provides the best possible care for consumers.

The Council's role with DDMHS has been changing. The Department has preferred to deal with individual providers versus the Council. The council is not in statute but the agencies themselves are named in the statute. Trust is an issue on the part of the Department and the Council. While there is usually DDMHS participation at monthly meetings, the Council does not think that the pla ying field is level.

Fundamental changes are needed in Vermont. The change needs to reflect a community-based treatment approach. VSH should not be the starting point of the system.

14. Mental Health Law Project (Legal Aid) & Vermont Protection and Advocacy

During this visit, PCG project members met with three individuals (two staff from the Mental Health Law Project and one staff member from Vermont Protection and Advocacy).

The relationship between VSG and the designated hospitals and community services should be examined.

Outpatient resources need to be critically examined, including the interaction between CMHC's.

MH Law project sees everyone who enters VHS through the civil system; they do the same work with the designated hospitals except around involuntary medication.

Protection and Advocacy works with people in prisons, VSH and all designated hospitals.
Primarily provides advocacy under the direction of attorney's. They focus on use of seclusion and restraints and any ADA / Olmstead issues.

All physicians at VSH under contract via Fletcher Alan-may not provide for direct line authority and accountability.

Most people are at VSH involuntarily and there is great concern to insure client rights.

There is a big difference between involuntary placement and involuntary medication.

There needs to be a range of treatment and service options available to people.

There should be an increase in crisis intervention capability in communities across the state.

Most people at VSH do not have family visits due to a number of reasons including: the geographic location, socio-economic issues, broken family ties; and homelessness.

There should be better collaboration between DDMHS and Corrections to improve the quality and quantity (availability) of mental health services.

There seems to be a disconnect between VSH and the rest of DDMHS-especially when it comes to getting people places.

Inpatient services cannot be looked at as though they exist in a vacuum and medication cannot be looked at as the answer to providing people with a safety net.

The structure of the system needs to change from a top-down approach to one that is more patient-centered.

15. Advocates and VSH Advisory Group

During this visit, PCG project members met with eight individuals.

The integration of physical health and mental health services is necessary. The current facility is not capable of conversion. The physical plant , the lack of a connection to a physical health hospital and the history of trauma at the facility make it incapable of being changed..

More of a research focus would help with the morale at the facility., it would move from an issue of custodial care to one of hope and recovery. This approach would also help eliminate the closed atmosphere which currently exists at VSH.

VSH does not function as part of the larger Vermont mental health system. There is no connection to the community services. VSH is isolated unto itself. DDMHS does not hold VSH to the same standards and expectation as it does other facilities (designated hospitals) and community services. A local community standing committees should be established to connect the system.

The Adult Mental Health State Program Standing Committee does not receive the same level of detail about VSH that it receives on other community services. This inconsistency creates an obstacle to its effectiveness.

A distinction needs to be made between the forensic/court order patients and the long-term population served at VSH.

The lack of resources dedicated to discharge planning creates problems in proper placement planning.

The designated hospitals have taken on much of the previous role of VSH but the clinical connection between the two needs to be strengthened.

The judicial system is out of synch with the mental health system. The courts and judicial system as a whole lack an understanding of the role of the designated hospitals in the mental health system.

DDMHS is not always responsive. The CRT directors compiled a report 3-4 months ago and submitted it to the Department. They are still waiting for a response.

There are issues with the competency and quality of staff at VSH. Staff are not always trauma treatment competent or even sensitive to issues of re-traumatization.

16. National Alliance for the Mentally Ill – Vermont Chapter

During this visit, PCG project members met with four individuals (Board members and staff).

VSH gets a bad rap. The staff and institution as a whole provide better care than they are given credit for. Many staff at VSH are compassionate staff but there are indeed staff that are not. On the whole, however, the staff is good. VSH Staff need to receive additional and ongoing training. Employees working at VSH and other state agencies have tough jobs and are underpaid for what they do.

Main problem with VSH is inordinate delay of receiving medication

VSH and the system need a recovery focus.

There needs to be some form of public oversight in order to ensure good care and maintain levels of accountability.

The court system moves too slowly. There is too much lag time between an involuntary commitment and the actual court hearing.

Communication is a significant problem within the system.

Safety and security vary across wards / units of VSH.

Discharge planning needs to be clearer so that there is a smooth transition into the community.

There is a shortage of case workers.

Forensic unit should be separated from other beds.

The current structure of VSH needs to change. There needs to be a central organization similar to what is in Waterbury today, but there should be other branches throughout the state. (i.e. three smaller facilities spread across the state.)

17. Vermont State Hospital Futures Project Open Forum

During this Open Forum, PCG project members met with twenty-one individuals. The forum was arranged by DDMHS to provide anyone with an interest in the future of VSH to have the opportunity to meet with PCG staff to discuss the project and obtain their input.

There needs to be the presence of a regular oversight body at VSH. There is an oversight body codified in law, but not in practice. This helps foster the atmosphere of a lack of attention and lack of accountability (of management and line staff). There needs to be independent oversight bodies with the power to litigate. In addition, all facilities should be licensed by DDMHS. (The Division of Licensing and Protection Services has been negligent.)

There are worries about what seems to be a revolving door policy at VSH. Many consumers are only at VSH because there is nowhere else to go. In this respect, VSH is merely serving as a warehouse.

VSH is not a safe and secure place for Vermonters. Consumers are sent to VSH because it is supposed to be a safe treatment setting for them but the current facility is anything but a safe setting. Many consumers never know what staff are going to do or how they are going to treat the patients.

There are perceived issues with VSH staff. Some staff generally care about the patients but a lot do not. The patients at VSH get a sense from some staff that they are only there for the paycheck. There needs to be more of a recovery feeling amongst staff. One way to change the culture at VSH is to provide the staff with more training and education.

VSH is a relic of an old system. There is nothing therapeutic about VSH and its approach to treatment. VSH needs to have smaller units and staff need to interact more with consumers so they feel like part of a community and not in a bubble. VSH should serve people who want to go there. When contemplating the idea of a new VSH, need to ask "what" and "how" in addition to the "where".

The legal element of the mental health system has not kept pace. The system is too slow in its handling of cases and evaluations. The lack of knowledge and experience in the mental health field of judges and the courts is detrimental to what is the best possible treatment and path for consumers.

The Mental Health Law Project exists for VSH consumers but there's no equivalent access to this resource for community consumers.

There needs to be increased levels of consumer choice and control.

The use of peer supports within the mental health system is effective. The use of peer supports in the community system (i.e. group homes such as Safe Haven) should be enhanced. In addition, DDMHS should contemplate ways in which peer supports can

be implemented within the state hospital and/or DDMHS structure. There have been successful examples of consumer-staffed offices within state agencies and is something that Vermont should look at.

Consumers perceive VSH to be an abusive and detrimental situation. There is a sense among patients that "by the time you are a good patient, you are ill-equipped to function in the world."

The protection of patients' rights for individuals at VSH needs to be increased.

The system cannot be one-size-fits-all. The system needs to be tailored to an individual's particular needs. In order to help accomplish this, there should be more consumer choice and control in the system.

Privatization of VSH would be a bad idea. There would be little, if any, accountability of a privately-owned and operated state hospital. The current lack of oversight and accountability is already problematic. This would only worsen the situation.

The current system has a bias for the medical model. Consumers should have a choice regardless of their state of mind. If the state or facility does have a problem with a consumer's state of mind, that's where the durable power of attorney would come in.

One of the major problems with VSH is the lack of trust. Staff violates patient confidentiality by talking about patients amongst themselves. The consumers staying at VSH do not trust most of the staff which inhibits their ability to recover from their illness.

There should be regular reporting from VSH and DDMHS to the Governor's Office. Doing so is one method that will help ensure that continuous oversight of VSH and its staff is maintained.

18. Vermont Psychiatric Survivors

During this visit, PCG project members met with ten individuals.

DDMHS communication with consumers needs to be better and much more consistent. Consumers and advocates strongly believe that "there shouldn't be anything about us without us" but it always seems to be the case that "there's always something about them without them".

VSH is a "psychiatric jail". The staff is like guards. The state needs to have a facility that is more like a hospital and needs to look at the staffing pattern to ensure that it is appropriate for the treatment setting. There is a strong belief that treatment is not occurring. There are very few workshops and the ones that exist are inadequate. There needs to be staff at VSH who partake in healing, not just prevention. In addition, there is no relationship to the community. VSH does not reach out and does not interface with the community or the community system.

There needs to be more of an emphasis on a recovery approach. Currently, there's still too much focus on chronic illness and fostering lack of hope, rather than recovery.

There is a need for a new VSH physical plant. The current physical plant should be closed and given to the Department of Corrections. As for the civil beds, a proposed solution involves two facilities. One facility will be dedicated to civil commitments that cannot be part of the 'upstream services' like Safe Haven in Randolph. The second facility should be used for court-ordered evaluations. There needs to be a hospital in Vermont but it can't have a set number of beds. (The bed amount needs to be fluid.)

There is still a belief that there is brutality, neglect, and lies at VSH. VSH has a very punitive orientation which is the last thing that the consumers need while trying to cope with a mental illness.

The mental health system needs to focus more on trauma. Consumers need individual trauma treatment inside and outside the facility. It is a significant issue for many consumers but is not given the necessary amount of treatment attention. Both the state hospital and community system need to become better trained in trauma treatment.

Fletcher Allen Health Care (FAHC) doctors contracted at VSH pose a problem to the system. These doctors should not be at VSH because they are not accountable to the Commissioner, DDMHS, or the State. Patients at the hospital also perceive a lack of care from the FAHC 'residents.' The current ties to FAHC need to be cut in order to get VSH treatment on the right track.

There is a need for more life skills programs at VSH. "If you have a broken spirit, nothing else will help." There should be programs similar to those that VSH used to have such as dances, working at local farms and metal shops. In addition, a program like pet therapy is helpful on the road to recovery.

Feedback loops are missing from the entire mental health system. One major weakness of the system is that not enough feedback is gathered from consumers and those affected by mental illness. Providing consumers with increased choice and control in the care process will help resolve this problem and improve the provision of appropriate care.

The atmosphere at VSH needs to improve. In order for recovery to occur, the environment at the hospital needs to be less punitive; the atmosphere needs to be more open, welcoming, compassionate, and geared towards recovery. For many patients at the hospital, being at VSH makes them feel as though they are at rock bottom.

The state mental health system is extremely fragmented. There is a lot of care and a lot of good people working in the system, but there are too many communication and continuum of care gaps.

There are some critical needs at VSH that need to be addressed. More clinicians and community-like staff need to be hired; occupational therapy needs to be enhanced; more money needs to be spent at VSH so that the environment is oriented to recovery and that

more programs exist for consumers. There is too much forced treatment going on at the hospital despite Act 114.

There should be a smoking room at VSH to accommodate the needs of some consumers. Nicotine and smoking should not be prohibited if it is part of a consumer's daily habits. Nicotine withdrawal should not become an issue when more serious illnesses are at hand.

Consumers should be encouraged to have a crisis plan and durable power of attorney (DPOA).

Community diversion and step-down programs like Safe Haven need to be replicated. The capacity of this facility type needs to be increased in the community in order to bolster the continuum of care. Doing so will also provide more opportunities to incorporate the use of peer supports and peer mentors.

There needs to be more individualized treatment programs. With VSH and some aspects of the current mental health system, the state is trying to pound square pegs into round holes.

Agencies should have one staff member fully dedicated to housing programs.

19. Public Feedback via the Vermont State Hospital Futures Project email address

In order to accommodate as much public feedback as possible regarding the future of VSH, PCG established an email address to which stakeholders could submit comments, suggestions, and ideas. The following feedback is a summary of perspectives conveyed in these emails. A total of 13 emails were received by this address.

The current VSH physical plant should be closed as a hospital. The space should be given to the Department of Corrections and used to operate a forensic unit. Current VSH staff could be given the option of moving with whatever beds are moved to DOC.

Steps need to be taken to change the institutional culture at VSH. There are question and concerns regarding staff training and attitudes. Patients at VSH feel they are not viewed by the majority of staff as people. Treatment and recovery is not the focus of many staff members; staff has a warehousing attitude. This setting contributes to consumers recycling through the VSH system.

Accountability problems exist at VSH with the doctors being employed by Fletcher Allen Health Care, and not directly answerable to the DDMHS Commissioner. There are concerns regarding the presence of "barely trained residents" at VSH and how this may negatively impact patient recovery. (Some believe that residents are not trained well enough and do not know how to provide the care required by VSH patients.) Contracting with FAHC doctors, while perhaps convenient for VSH, carries a lack of accountability.

There should be a new VSH facility that separates civil and forensic patients. Build two new facilities, each with patient capacity of 20-25 patients, one for civilly committed

cases and persons brought in on emergency exam, the other for persons charged with crimes and sent by the District Court for competency exams (i.e. forensic examination). Mixing forensic patients with civilly committed patients in the relatively close quarters of VSH is detrimental to the recovery process.

More "upstream services" ought to be available to divert most individuals who currently land in VSH repeatedly from being there at all. If user-friendly, respectful, helpful places exist, clients will use them. These upstream services ought to include: crisis residences throughout the state, modeled on the WCMHS Home Intervention Program; residences for individuals considered to be homeless and mentally ill, modeled on the Randolph Safe Haven, jointly run by VERMONT Psychiatric Survivors and the county mental health agency; "alternative treatment" crisis residences (three are specifically recommended), much like Home Intervention except not utilizing the medical model, for persons who do not find the medical model useful; and more "wraparound" teams for individuals with a significant history of institutional living and high degrees of challenge; at least one client drop-in center per catchment area. In addition to these settings, clients should be provided with a double safety net of both a Crisis Plan and a Durable Power of Attorney for Health Care. CMHCs need at least one staff member who focuses solely on consumer housing issues and at least one employee who assists clients in having any emotional support companion animals, and deals with landlords and other impediments to these healing relationships.

Designated hospital psych wards need to be much more accountable to DDMHS, and not allowed to do the current "cherry-picking" of accepting only the "easy clients".

There needs to be increased emphasis on recovery at VSH. To accomplish this task, one step would to set up recovery classes for all clients as well as all agency and hospital staffs. Another approach would be to provide much more education in the effects of psychological trauma, especially for psychiatric ward staff and emergency room staff. (Most emergency rooms are dreadfully disrespectful, and too often re-traumatize patients.)

There should be adequate initial diagnostic work-ups on all clients coming into the system, and easy access to additional testing when it seems useful. Testing and follow-up testing should be less of an administrative burden. Tests should be more readily available and that test sites are more accessible.

Forced treatment should be abolished. The forced medication of consumers should cease entirely and consumers should have more say in what medications they take. There should be increased consumer choice and control in the Vermont mental health system.

Treatment stopped at VSH about the time Case Rates began. Most centers used to have liaisons at VSH. This presence created a community and institutional treatment team which resulted in a continuity of care. Case rates capped the system and the easiest cuts were the liaisons.

Placing psychiatry in the management as opposed to treatment role hurt treatment at VSH. Since this occurred at VSH, the system as a whole has since taken on a disjointed treatment approach. There is no transition from the state hospital to the community care system. VSH is clinically isolated from the community system. Consumers essentially start from scratch once they reach the community. The presence of liaisons between VSH and the community help ensure a continuity of care; community facilities are able to take more complex patients and treat them successfully. In addition, treatment teams from the community working at VSH would help manufacture a seamless transition from VSH to the community.

VSH staff needs to receive continuous training. Staff at VSH are good people who are facing a difficult job. Most staff do not have the appropriate clinical training to provide patients the best level of care which prevents them from providing the appropriate level and quality of care.

There needs to be a strong link between the community-based system, the court system, and the hospital in a way that creates a sense of "oneness". There needs to be a community-based system that has a state hospital and courts as critical components. There needs to be leadership in place that is capable of creating this environment.

All consumers except forensic patients can be treated in a community-based hospital or rehabilitation center. The forensics population would cause significant community uproar, but people with borderline personality disorders and long term care patients could be treated in the community. Some believe that forensic evaluations should be located at a forensic facility. Patients should also be held at the same facility until a bed opens up at VSH. Forensic evaluations taking place in within the same space make other civil committed patients feel like they are in jail and not in a treatment setting. VSH still carries a significant stigma. Steps need to be taken to change the culture inside and outside of the institution. The first steps at ridding VSH of this stigma is making sure it can provide a safe and educational environment committed to improving the mental health of all its patients.

There are conflicting thoughts on where VSH should be located. Some would like to see VSH relocated to a more populated area of the state (i.e. Burlington), believing that larger areas will draw more committed medical personnel. Others believe that the small size of the state only justifies one state hospital facility as opposed to multiple facilities, and that facility should be central.

Consumers at VSH need to be a part of their treatment plan. Consumers need to have an input mechanism when it comes to medications and amounts of medications, as well as other every-day components of their care.

VSH needs to be more compassionate towards its patients. Staff needs to become familiar with the specific needs of patients and be able to differentiate one patient from the next. In addition to becoming more familiar with the specific needs of patients, staff needs to become more sensitive to these needs.

Discharge planning needs to become more efficient and effective. There is currently too much delay in getting patients out of VSH for little or no reason.

VSH is necessary and needs to serve the small percentage of individuals who cannot be treated or managed in the community facilities and designated hospitals. Such populations include people who are dangerous and/or aggressive, people who refuse treatment, those with unpredictable behavior, and people who require closely-monitored care.

There are differences in treatment DOC provides to female and male inmates with mental illness. The Department of Corrections (DOC) does not operate a unit providing services for women with mental illness, but does operate one for male inmates. Women who cannot live amongst the general population of the prison are either placed in segregation or sent to VSH for treatment. (The same occurs with male offenders who can't live on the mental health unit.) VSH tries to return female offenders to DOC custody as soon as possible. VSH needs to improve the quality of services for both male and female offenders. One option may be a forensic unit at VSH where DOC could send its most seriously mentally ill offenders.

There should be a significant increase in the availability and use of occupational mental health therapy at VSH. Life skills programs such as a comprehensive music program, a woodshop, a farm, a machine shop, a horticultural nursery, a restaurant, a beauty shop, and a clothing store with hand made goods should be run by patients. Severely affected patients should have more exposure to this form of occupational therapy.

Any involuntary interventions used should be limited to those which are least restrictive, least intrusive and least traumatizing to the person subjected to them. These interventions should be determined on an individual-by-individual basis such as known values and stated preferences of patients (including those indicated in advance directives), life experiences such as trauma histories, or particular vulnerabilities. Individual choices should not be overridden by the state or VSH.

All restraints used on individuals with psychiatric disabilities at VSH, designated hospitals, or correctional settings should be evaluated by the State. Vermont needs to pass statutes outlining new methods or revising current methods of seclusion, chemical and physical restraint, and interventions.

Peers at VSH should have more than just an advisory role or be limited to special projects. Peers should have a more regular role in the system by perhaps creating paid positions. Another approach would be to develop an 'office of consumer affairs' or similar agency that places peers in an administrative role. Both methods have precedent in other states and help bring peers deeper into the realm of service delivery, program design and policy making.

20. Agency of Human Services (AHS)
Department of Developmental and Mental Health Services

Secretary, AHS
DDMHS Commissioner
Interim Medical Director, VSH
Nursing Administrator
Assistant Executive Director
Interim CEO, VSH
VSH Psychiatrists & Medical Staff
VSH Social Workers & Psychologists
Director, Division of Licensing & Protection (Dept. of Aging & Disabilities)
DDMHS Adult Mental Health Staff
DDMHS Attorney General's Staff

PCG met with a total of 35 individuals on the campus of VSH. These individuals provided the PCG project team members in attendance with the following feedback.

VSH is in a state of transition. Although the study was planned prior to the recent suicides, these events are paramount on people's minds and have affected operations throughout the hospital. Staff is in a "wait and see" mode and expects significant changes to come about. Therefore, they are hesitant to initiate any change themselves.

There is an unusual mix of patients at VSH. There are three units at VSH: *Brooks I*, with 19 beds, primarily serves as a men's admission unit (although there is one female on this unit) and serves the few forensic patients at VSH; *Brooks 2* has 21 beds and serves as a women's / acute admission unit; and *Brooks Rehab* serves sub-acute, long terms patients. (There are few admissions to this 12 bed unit.) Because of a lack of sufficient size of any one sub-group (i.e. forensic, TBI, dual diagnosed MH / DD) it is difficult to develop specialized programs to meet their specific treatment needs. These populations co-exist in each unit and staff must alter their approaches to patients continuously. The result is that treatment is essentially custodial in nature.

Change is difficult at VSH. There are components of an institutional mindset at VSH. Staff is unionized and accustomed to doing things a certain way. Some resistance is expected if new changes are implemented.

There is a focus on medication at VSH. It is difficult for staff to engage with patients who have chosen not to take medication. It is felt by some that staff does not do enough to engage clients in treatment planning. There is an "if you are not on meds, we can't help you" attitude that prevails at VSH. It is felt that other hospitals do a better job at providing alternatives.

VSH does all court-ordered evaluations. All court-ordered evaluations go to VSH, even though other hospitals have the capacity and authority to complete these as well. Judges and mental health screeners automatically send patients to VSH without considering other options, partly because they have a poor perception of clinical care available at corrections facilities. Other hospitals are probably not interested in performing these

evaluations. It is estimated that half of all admissions to VSH come through the criminal justice system.

VSH is supposed to be "all things to all people". VSH serves as a safety net for more than just people with mental illness. They serve populations from corrections, developmental disabilities, public health, and veterans, and yet are funded only through mental health dollars. It is hard to for them to specialize in just serving people with mental illness. More clarity is needed about the role and mission of VSH.

VSH serves the hardest to treat patients. Because VSH is "all things to all people", they serve the people no one else will take. Designated hospitals are resistant to providing involuntary treatment, court ordered treatment, or care to those without a pay source. Therefore, the community relies on VSH to provide involuntary treatment, when necessary.

A new building for VSH, associated with a medical facility, is needed. There is universal agreement that the current building for VSH does not provide a therapeutic environment and is unacceptable. There is also strong support for a new facility to be "connected" to a medical facility to facilitate the relationship with physical health care. There are several ideas about which facilities could be used.

Consumers and advocates have a powerful voice. The consumer/advocacy movement is very strong in Vermont. Any changes in state laws diminishing client rights would be met with strong resistance. Collectively, they are very strong and have support in the legislature. An adversarial relationship exists between the advocates and "everybody else."

Doctors feel unsupported. Doctors feel it is difficult for them to do their jobs. They are working with limited resources in an older facility. The strong client rights movement makes it difficult to treat patients. Providing treatment involuntarily is difficult and takes time to process through court. It is frustrating for them to have patients in their unit that are refusing treatment of any sort. Doctors feel that outside forces are more interested in client rights instead of clinical care. Doctors are not employees of the state, but of Fletcher Allen Health Care.

Doctors believe that there are strong state laws regarding involuntary commitment and treatment. While the doctors feel that these laws impede critical patient care, advocates feel these laws protect client rights.

There is a need for more community resources. If more community resources were developed, there would be less of a reliance on VSH to treat certain populations. Resources such as assisted living facilities, transitional units, crisis beds, home interventions were recommended.

One million of new resources (mostly staff) have been put into the hospital over the last year. VSH is depleted of the resources necessary to provide "state of the art" care due to staffing and physical condition of the 70 year old building.

At VSH there is a lack of balance between the acuity level of the persons served and the staffing available.

The Department wants to find the balance between the other psychiatric hospitals and community services. This will help insure appropriate care and the role of VSH as the safety net for care for specific populations. VSH has asked private hospitals to treat more challenging patients. The Department perceives that a good relationship exists with other psychiatric hospitals in the state.

VSH has too much mixing of different populations. These populations include elderly, forensic, assaultive, vulnerable, chronic, and first break.

The Department does not want to "fix" the problems at VSH but rather to start all over. Significant problems are currently being uncovered. There is a desire to shift from being an institution to being a hospital. They would like to find the balance in addressing mental health and physical health needs. Due to the disconnect of mental health from physical health, a disproportionate amount of staff and time are spent transporting VSH patients to receive medical care.

21. Department of Corrections

During this visit, PCG project members met with four staff from the Department of Corrections (DOC).

A critical need is a secure mental health capacity for women. In general, there is a need to maximize resources at VSH for women in the correctional system. One possible idea is the development of a special unit on the grounds of VSH.

It is difficult for DOC correctional officers become trained in mental health treatment. The new prison in Springfield for men, which will open in January 2004, will have a block / unit for inmates with mental health issues. However, while the prison will have the space for individuals with mental illness, DOC is concerned that it will have the mental health expertise to provide the appropriate services. It is an issue for DOC to train correctional officers to become mental health technicians. DOC believes that it may be easier to train mental health technicians to become security technicians, but not vice versa.

Prisoners with serious mental health issues are put in segregation. Doing so is not an effective treatment mechanism for this population. This is, however, sometimes the only way to assure safety.

Working relations between Corrections and VSH need to improve. The question of who has the expertise to deal with the mental health issues needs to be answered. Corrections should not be attempting to duplicate services. Perhaps a joint effort to serving the forensics population could be arranged. Collaboration is a key step in finding the answer to the problems currently experienced. The ability to transfer people readily between VSH and DOC, and vice versa, is very difficult. In addition, persons

who are either being detained (pre sentencing or conviction) as well as people who are sentenced both present security issues (both men and women) at VSH.

The forensic population should not be the sole responsibility of DOC. Co-authority for/over individuals could be a win-win situation for both DOC and DDMHS. The accountability would most likely still rest with DOC because that is their role.

The reorganization of state government is attempting to address the silo functioning of state agencies. However, if not done appropriately, the policy and funding structures will remain in place and run contrary to the desired change.

There needs to be more clarity as to the court system's role in the mental health system. There are numerous questions that need to be answered in order to help the courts clarify their role. For instance, the system as a whole needs to improve how consumers are determined ineligible for treatment. The state also needs to look at statutes pertaining to shared responsibilities between DOC and DDMHS. DDMHS also needs more codified operational guidelines; DDMHS does many things via unwritten policy.

The resource crunch creates increasing service issues. Populations continue to present with more service needs and more complex issues but there are less resources in place to accommodate treatment.

National resources should be reviewed to determine state of the art approaches to managing mental health and corrections. The state should look towards resources such as the National Institute on Corrections and the Association of State Corrections Administrators (ASCA). These would be good places to begin an effort at restructuring the current mental health and corrections relationship, both programmatically and financially.

22. Department of Aging and Disabilities

During this visit, a PCG project member met with two individuals who were staff members.

Admission to VSH is a very complicated process. Admission to VSH usually only happens when the consumer is in crisis, their safety is at risk, and no community crisis bed can be secured.

Designated hospitals are not able to serve the Secure and Persistently Mentally Ill (SPMI) population. The designated hospitals need standards and expectations set for them. Designated hospitals are poorly managed.

VSH needs to look at best practices around treatment efficacy, physical plant, staffing, staff capacity, skills and training. Nurses are not appropriately trained in mental health issues and public sector work.

Further study should be conducted on the adequate number of psychiatric beds needed in Vermont. The state needs to determine the appropriate service capacity based on

population.

Community crisis systems do not work. More specifically, these crisis systems do not work for persons with traumatic brain injury (TBI) and mental health issues. A regional approach should be considered. The crisis staff/team needs to be appropriately trained and the team needs to have the right clinical composition.

VSH and the designated hospitals need to be managed in concert. These facilities and staff need to see themselves and each other as players in the same system.

Service transitions and placement settings need to be looked at. If a consumer is already on the waiver then they will return to the community if they are clinically able to do so. What usually happens is that the placement deteriorates to a point that the person cannot return. A better option would be to have intervention when the person started to need more or different support. A clinical team could intervene with the community staff to treat the person and work with them so the placement could be maintained.

VSH has a level of expertise that should be shared with the designated hospitals and the community service providers. Doing so will help improve care across the entire system.

VSH serves very few elderly persons. Elderly persons present with depression and suicidal tendencies but these are rarely recognized and only their physical health issues are dealt with. Elder care clinicians need to be available in each region of the state for consultation on an inpatient and outpatient basis.

The VSH physical environment presents a real challenge to quality care provision.

The institutional culture at VSH is driven by the day-to-day team leaders of the units. The skills and attitudes of these daily leaders are important and should be assessed and monitored. The middle management, supervisors technical skills should be evaluated.

23. Vermont Judge

During this visit, PCG project members met with one judge.

Hearing involuntary medication cases is a substantial use of the family court system resources. All cases are heard on Friday and are heard by a rotating judge using the family court facilities. However, the legal and mental health systems are in the process of establishing a court on the VSH campus which should be ready for start-up sometime soon. This should help reduce use of the family court system.

Court cases pertaining to mental illness and VSH are heard by multiple court systems. While involuntary medications are heard by the court presided over by the assigned judge, court-ordered evaluations are heard by the district court and by different judges.

The continuity of care and treatment are significant issues. In cases seen by this judge, there are clear issues around patients transitioning in to or out of VSH. The communication of treatment and care between the state and community system is not as

effective as it could be.

Act 114 is tangled and needs some interpretation. There needs to be good attorneys for both sides of cases in order for the true intent of Act 114 to come through. The legislature should consider revisiting this statue and making its complexity more clear.

24. Vermont State Legislators

Four legislators responded to the invitation to meet with members of the PCG project team to discuss the future of VSH and the statewide mental health system.

Fixing the problems at VSH will be a difficult and lengthy process. The legislators expressed a desire to do the right thing for Vermonters with mental health needs, but conceded that it will be difficult to solve all the problems immediately given the state's limited resources with multiple needs. The fixing process will be a matter of setting priorities.

The VSH physical plant needs attention. The physical plant is too old, isolated, and creates a stigma for people who receive services there. Recent renovations were not adequate to provide quality clinical services due to the mixture of people served. The physical environment of VSH limits what can be done there.

Future incidents need to be avoided by improving the quality of clinical care. Active treatment needs to be provided on an ongoing basis and best practices should be incorporated. If a new physical plant is needed it would be good if it could be designed to provide flexibility in treatment capacity. The appropriate amount of treatment should be provided to consumers for the appropriate amount of time; length of treatment should not be driven by the payment source. VSH should be a place that provides humane, quality and effective services to all Vermont consumers.

There are significant issues straining the community system. Pay for a community system worker is very low in comparison to VSH staff and the community workers have no bargaining power. Not in My Backyard (NIMBY) issues are alive and well in Vermont; we need to get to a place of tolerance, mutual respect, and kindness. Perhaps spreading placements around would benefit community connections. Repeat users of VSH need to access better community supports, screening, staff etc.

Mental Health services in corrections needs to improve, especially around co-occurring issues of substance abuse, mental health and involvement with corrections. There are numerous individuals under the control of the Department of Corrections who are not receiving appropriate mental health or substance abuse treatment.

The current strategic plan to bring VSH back into compliance with federal requirements may not have adequate buy-in and support to insure success.

Vermont needs a preventative focus. A long range view would be to more comprehensively address children's mental health issues to insure that an investment is made which will ultimately result in a savings in adult mental health system.

Act 114 is problematic. Act 114 creates problems with insuring the safety of the person refusing treatment and the others (staff and patients) involved or around the person. Need to balance a person's right to refuse treatment with the need to protect others.

X. Appendix B: Public Consulting Group, Inc. Project Team

PCG assembled a project team with the expertise needed to meet the goals outlined by DDMHS in this RFP. This multi-disciplinary project team contained staff with years of relevant experience working with the public and private sector behavioral health care industry, working with a wide range of stakeholders within the system, as well as completing extensive qualitative and quantitative analyses and reports of behavioral health care issues. PCG also collaborated with two subcontractors for the duration of this engagement to ensure that all of the Department's and State's needs were met with the highest level of experience and professionalism possible. Mr. Paul Barreira and Ms. Gail Hansen-Mayer bring a unique wealth of clinical expertise to an already experienced team of PCG staff.

Marc H. Fenton
Mr. Fenton, a Principal at PCG, is the Practice Area Director for the firm's Strategy and Operations Practice Area focusing on mental health, developmental disabilities and other human service agencies. He is the founder and Director of Public Partnerships, LLC, a PCG subsidiary that provides financial and other intermediary services to individuals with developmental disabilities and their families. Mr. Fenton routinely presents to state legislative bodies, elected officials and at public forums. His work has led to improvements in services, finances and management in more than twenty states. Mr. Fenton began his career as a public mental health / mental retardation administrator, responsible for community and institutional services in Massachusetts. He served as Superintendent of Medfield State Hospital for two years. Mr. Fenton has advanced degrees in public policy analysis, planning and management.

Cathy Anderson
Ms. Anderson, an Associate Manager at PCG, has been working in the field of developmental disabilities for over twenty years. Recently, she was the Chief Deputy Director for the Iowa Department of Human Services, where she was the Department's designated authority on Medicaid, mental health, and developmental disabilities. In Iowa she was responsible for policy setting for both community and institutional services for mental health, developmental disabilities and juvenile services. In Iowa, she was also responsible for the Behavioral Health Managed Care contract. In addition, Ms Anderson was involved in the work in Iowa to design a mental health system for adolescents and children. She spent seventeen years with the Nebraska Health and Human Services System, serving as the Administrator of the Southeast Service Area, the Director of the Developmental Disabilities System, the Community Services Program manager, and a Program Specialist and Quality Assurance Coordinator. In Nebraska the operations of the Beatrice State Developmental Center; the only state operated ICF-MR, were part of her responsibilities. Ms. Anderson has been a Qualified Mental Retardation Professional since 1978 and is a member of the American Association on Mental Retardation. She has served as the President, Vice President, and on the Board of Directors for the National Association of State Directors of Developmental Disability Services.

Sean M. Dunbar
Mr. Dunbar, a Business Analyst, has been at the firm since August 2001. As a member of the Strategy and Operations Practice Area, he has been involved with a variety of strategic planning projects in the behavioral health care field. Projects to date have included: consulting engagements with the State of Connecticut's Community Mental Health Strategy Board, where he helped design and develop the Board's Strategic and Financial Assistance Plans; HealthChoices implementation projects in various Pennsylvania counties; as well as Olmstead bed study work for the Commonwealth of Massachusetts Department of Mental Health. Mr. Dunbar has worked recently with the State of North Carolina's Office of the State Auditor on a statewide educational and clinical assessment of the State's Youth Development Centers for juvenile offenders, as well as with New Hanover County, NC, where he researched model programs and funding streams to assist the County's Juvenile Crime Prevention Council implement prevention-based initiatives for at-risk youth. Both these engagements included extensive collection of stakeholder input and development of comprehensive final reports.

Linda M. Cabral
Ms. Cabral, a Consultant at PCG, has experience in the policy analysis and strategic planning of public behavioral health and developmental disabilities services. Ms. Cabral serves as project manager on various initiatives with local providers, state mental health and developmental disabilities agencies, and health and human service agencies on service development, quality assurance, program assessment, evaluation and organizational development. These projects typically require working with multiple stakeholders successfully (consumers, providers, funders, managed care organizations). Ms. Cabral often provides facilitation services and plans and conducts focus groups and public forums. In addition, she has completed large statewide capacity assessments publicly funded behavioral health services. Recently, she has been aiding counties in North Carolina in their local business planning. Before coming to PCG, Ms. Cabral was part of the research team at the National Maternal and Child Health Policy Center at Brandeis University. There, she focused on evaluating a carve-out system for adolescents with substance abuse disorders. She has a Master of Management and Health Policy from the Heller School at Brandeis University. *Ms. Cabral was a member of the project team during the early stages of the study but stepped down from her position at PCG to pursue other professional endeavors.*

The PCG clinical team included:

Stuart Koman, Ph.D.
Dr. Koman, a Senior Clinical Consultant, will provide expertise in the areas of behavioral health services, operations assessment, utilization management, quality management, strategic planning, and case rate reimbursement. He has been part of PCG's public healthcare strategy services consulting team for the past five years. Dr. Koman has been involved in behavioral health services for over fifteen years and served as co-founder, President, and CEO of Choate Integrated Behavioral Health Care, Inc. At Choate, Dr. Koman owned and managed psychiatric hospitals, directed hospital psychiatric programs by contract, and re-organized the way in which care management

services are facilitated. Dr. Koman was instrumental in developing a range of managed care administrative services at Choate, as well. Dr. Koman has worked with many public and private hospitals and agencies to expand, privatize, and maximize program operations. He has a doctorate in Clinical Psychology.

Paul Barreira, M.D.
Paul J. Barreira is Chief of Community Clinical Services and Director of Medical Education at McLean Hospital. He is also Program Director of McLean's Waverley Place, an innovative community based rehabilitation program. Dr. Barreira is an Associate Professor of Psychiatry at Harvard Medical School. McLean Hospital is the largest psychiatric component of the Massachusetts General Hospital and Partners HealthCare System and the largest psychiatric clinical teaching and research affiliate of Harvard Medical School. Before coming to McLean in 2000, Dr. Barreira served as the Deputy Commissioner of Clinical and Professional Services for the Massachusetts Department of Mental Health from 1996-2000. During his tenure he was instrumental in developing clinical practice guidelines for the treatment of individuals with schizophrenia and bipolar disorder who receive coverage through Medicaid and DMH. He also spearheaded efforts to work with Medicaid to provide better medical care to DMH clients and led the development of a statewide database tracking the use of seclusion and restraint on inpatient units.

Gail Hanson-Mayer, RN, CS, MPH, CADAC
Gail Hanson-Mayer is the Vice President of Clinical Operations for Sterling Resources LLC. She has a combined 23 years of experience in the field of behavioral health, which includes senior management positions with national and local companies that provide behavioral health management and consultation services to hospitals, managed care companies, behavioral health networks and state systems of care. She has provided consultation in the areas of program development and evaluation, licensing and accreditation preparedness and review, contracting, credentialing and financial management and the development of integrated systems of care. She is also currently continues to provide direct care to adolescents and adults in an outpatient group practice as a Clinical Nurse Specialist with prescriptive authority.